IN THE

Supreme Court of the United States

OCTOBER TERM 1977

No. 76-1412

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell, Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Respondents.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,

Respondents.

Appendix to Petition for Writ of Certiorari to the Supreme Court of the State of New Jersey

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SUPERIOR COURT OF NEW JERSEY

CHANCERY DIVISION

HUDSON COUNTY

DOCKET NO. C-2684-71

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Plaintiffs,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, the Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, the Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Defendants.

COMPLAINT
(Filed December 4, 1972)

Plaintiffs, by way of Second Amended and Supplemental Complaint say:

Plaintiffs, John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO (TRUSTEES) bring this action individually and as a Class Action on behalf of all other Trustees of Welfare Funds of Labor Unions in the State of New Jersey similarly situated against the defendant hospitals to recover damages for violation of plaintiffs' rights under the Constitution and Laws of the United States of America and under the Constitution and Laws of the State of New Jersey, and to enjoin defendants from the continuing and further violation of those rights. Plaintiff, Howard Marks brings this action individually and as a Class Action on behalf of all members of Labor Unions similarly situated who are eligible to receive benefits under a Union Welfare Plan in effect in the State of New Jersey against the defendant hospitals to recover damages for violation of plaintiffs' rights under the Constitution and Laws of the United States of America and under the Constitution and Laws of the State of New Jersey, and to enjoin defendants from continuing any further violations of those rights.

CLASS ALLEGATIONS

Plaintiff Trustees are entrusted with the protection of the rights, privileges and benefits of members of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO who are eligible to receive benefits from the Welfare Fund of Local 464, pursuant to the terms of

the Welfare Plan. The members of the Class represented by Plaintiff Trustees are all Trustees of Welfare Funds of Labor Unions in the State of New Jersey who are charged by defendant hospital rates in excess of the rates charged to Blue Cross - Blue Shield Plan of New Jersey by the defendant hospitals for the same or similar services.

Plaintiff Marks is a member of Local Union 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO who is eligible for benefits from the Welfare Fund of Local 464 pursuant to the terms of the Welfare Plan. The members of the Class represented by plaintiff Marks are all those members of Labor Unions similarly situated who are eligible to receive benefits from a Union Welfare Fund for medical services, treatment or facilities provided by defendant hospitals in the State of New Jersey.

The class represented by Plaintiff Trustees and plaintiff Marks is so numerous that joinder of all members is impractical.

There are questions of law and fact common to the Class. The claims of plaintiff Trustees and plaintiff Marks are typical of the claims of the Class.

Plaintiff Trustees and plaintiff Marks will fairly and adequately protect the interest of the Class.

The defendant hospitals have acted on ground generally applicable to the Class and injunctive relief with respect to the Class is appropriate.

The question of law and fact common to the members of the class predominate over any questions affecting only individual members and a Class Action is superior to other available methods for the fair adjudication of the controversy between the parties herein.

PLAINTIFFS

1. Plaintiffs, John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, are Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO. The principal office of the Welfare Fund is maintained at 67 Sanford Street, in the City of East Orange, County of Essex and State of New Jersey. Plaintiff, Howard Marks, is a member in good standing of Local 464 and resides at 133 Avenue B, in the City of Bayonne, County of Hudson and State of New Jersey.

DEFENDANTS

2. Defendant, Bayonne Hospital, maintains its principal office at East 29th Street, in the City of Bayonne, County of Hudson and State of New Jersey.

3. Defendant, Beth Israel Hospital maintains its principal office at 70 Parker Avenue, in the City of Passaic, County of Passaic and State of New Jersey.

3a. Defendant, Bergen Pines County Hospital maintains its principal office at 1 Ridgewood Avenue, in the Borough of Paramus, County of Bergen and State of New Jersey.

4. Defendant, Clara Maass Memorial Hospital, maintains its principal office at Franklin Avenue, in the Town of Belleville, County of Essex and State of New Jersey.

5. Defendant, Englewood Hospital Association, maintains its principal office at 350 Engle Street, in the City of Englewood, County of Bergen and State of New Jersey.

6. Defendant, Greater Paterson General Hospital, maintains its principal office at 528 Market Street, in the City of Paterson, County of Passaic and State of New Jersey.

7. Defendant, Hackensack Hospital, maintains its principal office at 22 Hospital Place, in the City of Hackensack, County of Bergen and State of New Jersey.

8. Defendant, Irvington General Hospital, maintains its principal office at 832 Chancellor Avenue, in the Town of Irvington, County of Essex and State of New Jersey.

9. Defendant, Holy Name Hospital, maintains its principal office at 718 Teaneck Road, in the Township of Teaneck, County of Bergen and State of New Jersey.

10. Defendant, The Hospital Center at Orange, maintains its principal office at 188 South Essex Avenue, in the City of Orange, County of Essex and State of New Jersey.

11. Defendant, Morristown Memorial Hospital, maintains its principal office at 100 Madison Avenue, in the Town of Morristown, County of Morris and State of New Jersey.

12. Defendant, Monmouth Medical Center, maintains its principal office at 200 2nd Avenue, in the City of Long Branch, County of Monmouth and State of New Jersey.

13. Defendant, Mountainside Hospital, maintains its principal office at Bay & Highland Avenue, in the Town of Montclair, County of Essex and State of New Jersey.

14. Defendant, Newark Beth Israel Medical Center, maintains its principal office at 201 Lyons Avenue, in the City of Newark, County of Essex and State of New Jersey.

15. Defendant, Riverdell Hospital, maintains its principal office at 576 Kinderkamack Road, in the Borough of Oradell, County of Bergen and State of New Jersey.

16. Defendant, Saddle Brook Hospital, maintains its principal office at 300 Market Street, in the Township of Saddle Brook, County of Bergen and State of New Jersey.

17. Defendant, Saint Barnabas Medical Center, maintains its principal office at Old Short Hills Road, in the Township of Livingston, County of Essex and State of New Jersey.

18. Defendant, St. Michael's Medical Center, maintains its principal office at 306 High Street, in the City of Newark, County of Essex and State of New Jersey.

19. Defendant, South Amboy Memorial Hospital, maintains its principal office at 540 Bordentown Avenue, in the City of South Amboy, County of Middlesex and State of New Jersey.

20. Defendant, St. Joseph's Hospital, maintains its principal office at 703 Main Street, in the City of Paterson, County of Passaic and State of New Jersey.

21. Defendant, St. Mary's Hospital, maintains its office at Fourth Street and Willow Avenue, in the City of Hoboken, County of Hudson and State of New Jersey.

22. Defendant, St. Mary's Hospital, maintains its principal office at 211 Pennington Avenue in the City of Passaic, County of Passaic and State of New Jersey.

23. Defendant, Richard McDonough is the Commissioner of Insurance of the State of New Jersey and is empowered and charged by the Legislature of the State of New Jersey with the responsibility as set out in Titles 17 and 26 of the New Jersey statutes to supervise, regulate and, in consultation with the Commissioner of Health, approve the rate of payment to be made by hospital service corporations to health care facilities.

24. Defendant, James R. Cowan, M.D. is the Commissioner of Health of the State of New Jersey and is empowered and charged by the Legislautre of the State of

New Jersey with the responsibility as set out in Titles 17 and 26 of the New Jersey statutes to supervise, regulate and, in consultation with the Commissioner of Insurance, approve the rates of payment to be made by hospital service corporations to health care facilities.

25. The defendant, Blue Cross - Blue Shield Plan of New Jersey is a corporation of the State of New Jersey under the Laws of the State of New Jersey maintaining its principal office at 33 Washington Street, in the City of Newark, County of Essex, State of New Jersey and is engaged in the business of providing health insurance plans in the State of New Jersey.

FIRST COUNT

26. On April 9th, 1971, Howard Marks, a member of Local 464 and an eligible beneficiary of the Welfare Plan of Local 464, was admitted as a patient to the Bayonne Hospital for treatment and medical services. Trustees of the Fund were required to pay to the defendant hospital the sum of $65.00 per day for a semi-private room for Mr. Marks. For these services and for other services the Plaintiff Trustees and the Fund were required to pay an amount of money in excess of the amount required to be paid by the Blue Cross-Blue Shield Health Services Plan, on behalf of persons who are eligible for benefits under the Blue Cross - Blue Shield Plan for the same or similar services, treatment, and facilities.

27. There is no factual distinction between the health services, treatment or facilities provided to the Union beneficiaries of the Fund and the similar services, treatment and facilities provided to persons covered under the Blue Cross-Blue Shield Plan, nor is there any substantive or rational basis for the defendant hospital to require payments from

the Trustees of the Welfare Fund in amounts in excess of the payments required to be paid to the hospitals by the Blue Cross-Blue Shield Plan for the same or similar services.

28. Each of the defendant hospitals have engaged in acts of discrimination against the plaintiffs, and all members of plaintiffs' class, to wit, they have demanded and received sums of money at a rate in excess of the rate demanded and received from the Blue Cross-Blue Shield Plan of New Jersey to provide the same or similar medical service, treatment and facilities.

29. Defendant hospitals by virtue of their financial support and structure, tax status and benefits, functions, associations and affiliation with local state and federal units of government, and by virtue of their licensing, certification, examination and authorization by the State of New Jersey and the United States of America to engage in the offering of hospital and medical services and the receipt of compensation therefrom, have assumed a governmental nature and are engaged in governmental activities.

30. The above described acts of discrimination by defendant hospitals against plaintiffs, and all members of plaintiffs class, constitute illegal discriminatory state action.

31. Said acts of discrimination by defendant hospitals constitute a deprivation, without due process of the right to protect property contrary to the provisions of Article I, paragraph I of the Constitution of New Jersey.

32. As a result of the above described discriminatory acts, plaintiffs have suffered injury and will continue to suffer injury and unless said acts are enjoined, plaintiffs will suffer irreparable injuries.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Directing the defendant hospitals to immediately offer to make available to plaintiffs and all members of plaintiffs' class, services, treatment and facilities at a rate schedule of payments equal to and as favorable as the rate schedule for payments offered and made available to Blue Cross-Blue Shield Plan of New Jersey.

D) Defendants, by way of damages, pay into the Court a sum of money, to be held in escrow for the benefit of all injured persons, equal to any and all sums of money demanded and received at any time by the defendant hospitals from any persons in excess of the amount of money they would have been required to pay under the rate schedule made available to Blue Cross-Blue Shield Plan of New Jersey.

E) Directing that the defendant hospitals pay to the plaintiffs a rea nable counsel fee, costs of suit plus interest.

SECOND COUNT

33. Plaintiffs repeat, reiterate and make a part herein of all the allegations set out in the previous count of this Complaint.

34. Plaintiff trustees, and all members of the class of trustees, are responsible for the administration of welfare funds of labor unions pursuant to welfare plans and are obliged to protect the rights, privileges and benefits of members of labor unions who are eligible for fund benefits. Plaintiff Marks and all members of the class of beneficiaries of welfare funds, are members of labor unions in New Jersey who are eligible for benefits from a labor union welfare plan.

35. The terms, assets and benefits of the above described welfare plans are the subject of collective bargaining by the labor unions and employers.

36. Defendant hospitals have engaged in acts of discrimination by demanding and receiving from plaintiffs, and members of plaintiffs class sums of money in excess of sums of money demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the furnishing of medical services, treatment and facilities.

37. By the above described acts of discrimination, defendant hospitals have caused the assets of the welfare funds, of which plaintiffs are trustees and beneficiaries, to become depleted and diminish in value.

38. The above described acts of discrimination by defendant hospitals constitute an infringement and deprivation of the right of plaintiffs to organize and bargain collectively, contrary to Article I paragraph XIX of the Constitution of New Jersey.

39. As a result of said infringement, impairment and deprivation, plaintiffs have suffered injury and unless and until said wrongful acts are enjoined, plaintiffs will continue to suffer irreparable injuries.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Directing the defendant hospital to immediately offer to make available to plaintiffs and all members of plaintiffs' elass, services, treatment and facilities at a rate schedule of payments equal to and as favorable as the rate schedule for payments offered and made available to the Blue Cross-Blue Shield Plan of New Jersey or any other Health or Welfare Plan.

D) Enjoining the defendant hospitals from any acts which constitute infringements, impairment and deprivation of the plaintiffs right to organize and bargain collectively.

E) Directing that the defendant hospital pay to the plaintiffs a reasonable counsel fee, costs of suit plus interest.

THIRD COUNT

40. Plaintiffs repeat, reiterate and make a part herein all the allegations previously set out in the Complaint.

41. Hospital services and services incidental thereto (medical or otherwise) are fundamental needs and human

rights protected by the due process clause of the 14th Amendment to the Constitution of the United States and require the equal protection of the laws in accordance with that Amendment.

42. The defendant hospitals, acting under color of law, have engaged in activities which constitute a denial to the plaintiffs and all members of plaintiffs' class the equal protection of the laws in that the defendants have dealt with persons similarly situated in an arbitrary and discriminatory manner.

43. More particularly describing the activities referred to in paragraph 42 the defendant hospitals, in their governmental nature and by way of performing governmental functions have applied an unequal and discriminatory rate schedule applied to a similarly situated persons, namely, Blue Cross-Blue Shield Plan of New Jersey for the same or similar services, treatment or facilities.

44. The above described acts of the defendant hospitals have resulted in injury to the plaintiffs and constitute State denial to persons within its jurisdiction of the equal protection of the laws in contravention of the provisions of Section 1 of Fourteenth Amendment of the United States Constitution.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Directing the defendant hospitals to immediately offer to make available to plaintiffs and all members of plaintiffs' class, services, treatment and facilities at a rate schedule for payments offered and made available to the Blue Cross-Blue Shield Plan of New Jersey or any other Health or Welfare Plan.

D) Directing that the defendant hospital pay to the plaintiffs a reasonable counsel fee, costs of suit plus interest.

FOURTH COUNT

45. Plaintiffs repeat, reiterate and make a part herein all of the allegations previously set forth in this Complaint.

46. In accordance with N.J.S. 17:48-7 the rates of payment by a hospital service corporation, including the Blue Cross-Blue Shield Plan of New Jersey made pursuant to a written contract to a hospital or institution for service contracted thereunder are required to be approved as to reasonableness by the Commissioner of Insurance, defendant Richard McDonough.

47. Defendant Richard McDonough, in the exercise of the above described power to approve as to reasonableness, has acted in a discriminatory and unfair manner and thereby has created an invidious classification in relationship to the plaintiffs in that such classfication is

irrational, discriminatory and denies to the plaintiffs and all members of plans of hospital service corporations, except the Blue Cross-Blue Shield Plan of New Jersey, the equal protection of the laws in contravention of the provisions of Section I of the Fourteenth Amendment of the United States Constitution.

48. More particularly specifying the denial of equal protection of the laws by the defendant Commissioner, the Commissioner has approved the plan and imposition upon the plaintiffs by the defendant Blue Cross-Blue Shield Plan of New Jersey, the equal protection of the laws in contravention of the provisions of Section I of the Fourteenth Amendment of the United States Constitution.

48. More particularly specifying the denial of equal protection of the laws by the defendant Commissioner, the Commissioner has approved the plan and imposition upon the plaintiffs by the defendant Blue Cross-Blue Shield Plan of New Jersey Inc. and the defendant hospitals of an exorbitant and excessive rate for the same or similar services offered to the Blue Cross-Blue Shield Plan Inc. of New Jersey for a lower rate. The rates of payment approved by the Commissioner are based upon a calculation which imposes penalty upon the plaintiff and a discount to the Blue Cross-Blue Shield Plan of New Jersey Inc. Said discount is directly dependent upon the discriminatory rates imposed upon the plaintiffs and approved by the Commissioner.

49. The above described actions of the defendant Richard McDonough were done in his capacity as a representative of the State of New Jersey and in pursuance of a specific regulatory function as mandated by the above designated State Statute and thereby such actions constitute illegal state action, and have resulted in injury

and loss of property and valuable assets to the plaintiffs and all members of plaintiffs' class and constitute a deprivation by the State of New Jersey of the property of plaintiffs and all members of plaintiffs' class without due process of law, in contravention of the provisions of Section I of the Fourteenth Amendment of the Constitution of the United States.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Defendants, by way of damages, pay into the Court a sum of money, to be held in escrow for the benefit of all injured persons, equal to any and all sums of money demanded and received at any time by the defendant hospitals from any persons in excess of the amount of money they would have been required to pay under the rate schedule made available to Blue Cross-Blue Shield Plan of New Jersey.

D) Directing the defendant hospitals to immediately offer to make available to plaintiffs and all members of

plaintiffs' class, services, treatment and facilities at a rate schedule for payments offered and made available to the Blue Cross-Blue Shield Plan of New Jersey or any other Health or Welfare Plan.

E) Directing that the defendant hospitals pay to the plaintiffs a reasonable counsel fee, costs of suit plus interest.

FIFTH COUNT

50. Plaintiffs repeat, reiterate and make a part hereof all of the allegations previously set forth in this Complaint.

51. Pursuant to N.J.R.S. 17:48-7 and 26:2H-18 the rates of payment by a hospital service corporation including the Blue Cross-Blue Shield Plan of New Jersey made pursuant to a written contract with a health care facility, are required to be approved by the Commissioner of Health in consultation with the Commissioner of Insurance is required to certify the cost of providing health care services as reported by each health care facility, and the Commissioner of Insurance with the approval of the Commissioner of Health is empowered to evaluate the reasonableness of proposed contractual payments by hospital service corporations to meet those costs. The law requires the Commissioners in making their respective determinations to take into account the total operating costs of the health care facility.

52. Defendants Richard McDonough and James R. Cowan, M.D. in the exercise of their statutory authority have acted in a discriminatory, unfair and illegal manner in failing to take into account, for the purpose of establishing the rates of payment to be made by the Blue Cross-Blue Shield Plan of New Jersey, all of the costs of the respective health care facilities. They have thereby

created a classification which is irrational and discriminatory and which denies to plaintiffs and all members of plaintiffs' class the protection contemplated by the statute.

53. More particularly specifying the unlawful and discriminatory acts of defendant Commissioners, said Commissioners in approving the rates of payment to be made by the Blue Cross-Blue Shield Plan of New Jersey to defendant hospitals have failed to take into account some of the costs necessary to the operation of defendant hospitals, as a result of which said hospitals must and do charge plaintiffs and others similarly situated not just for the value of services rendered, but an additional sum to make up for the deficiency in the payment by Blue Cross-Blue Shield. The approval by the Commissioner of a discount for Blue Cross-Blue Shield results in a discriminatory rate and imposes a penalty upon plaintiffs in violation of the laws of the State of New Jersey as aforesaid.

54. As a result of the illegal acts of the Commissioners of Health and Insurance as herein set forth the assets of plaintiffs' Welfare Fund and the assets of the welfare funds of all members of plaintiffs' class have been diminished, depleted and impaired.

55. In the alternative, plaintiffs allege that if the acts of the Commissioners of Health and Insurance herein complained of are found to be permissible under Titles 17 and 26 of the Laws of the State of New Jersey, then such laws as construed and applied by the Commissioners are repugnant to the equal protection clause of the Fourteenth Amendment to the Constitution of the United States and contravene such clause to the extent to which they authorize unequal and unfair rates and charges to plaintiffs and to other members of plaintiffs' class.

WHEREFORE, plaintiffs demand Judgment:

A) Directing the Commissioner of Insurance and the Commissioner of Health to withdraw their approval of the present and discriminatory rate pattern and to require the establishment of contractual relations between defendant hospitals and the Blue Cross-Blue Shield Plan of New Jersey under which the latter will be required to pay at the same rate as is required of plaintiffs for similar services, treatment and facilities.

60. More particularly specifying the acts and conspiracy of defendants set out in paragraph 59 above, the defendant hospitals, with the approval, consent, and cooperation of the officers, employees and directors of the Blue Cross-Blue Shield Plan, have offered and made available to the Blue Cross-Blue Shield Plan, health services, facilities and treatment at a rate of payment less than the rate of payment offered and made available to the plaintiffs, and to members of plaintiffs' class, for the same or similar services. Said acts and conspiracy have been in furtherance of the monopolization and the attempt to monopolize the commerce and trade of providing group health services. More particularly specifying the said acts and conspiracy, the defendant, together with the officers, employees and directors of the Blue Cross-Blue Shield Plan, have attempted to and have depleted the assets of plaintiff trustees welfare fund and thereby are acting toward the purpose of eliminating plaintiff trustees, and members of plaintiff trustees' class and other persons in the business of group health insurance from the commerce and trade of providing group health services and insurance.

61. The acts and conspiracy of defendant hospitals and the officers, employees and directors of Blue Cross-Blue Shield Plan, have been in furtherance of a plan and a

scheme to eliminate competition, and more particularly, the defendant hospitals by practicing discrimination towards the plaintiffs and all members of plaintiffs' class in charging them exorbitant and higher rates, have thereby made it possible for them to provide a discount rate schedule to the Blue Cross-Blue Shield Plan.

62. The acts and conspiracy of defendant hospitals and the officers, employees and directors of Blue Cross have been in furtherance of a common plan and a mutual scheme, in violation of the New Jersey Anti Trust Act (N.J.S.A. 56:9-1 et seq), to charge the plaintiff and members of the class of unions similarly situated more than subscriber's of defendants' Blue Cross for the same equipment, facilities and services, thus depriving plaintiff and members of their class of their property by reason of such acts, conspiracy, common plan, mutual scheme and monopolization in violation of the provisions of the New Jersey Anti Trust Law.

63. As a result of the above described acts and conspiracy of defendants, the assets of plaintiffs' welfare fund and the assets of all of plaintiffs' class have been diminished, depleted and impaired. Until and unless defendants are permanently enjoined and restrained from continuing such conspiracy, acts and practices, the plaintiffs will suffer further losses and irreparable damage.

64. The above described acts, conspiracy, common plan, mutual scheme, restraint of trade and monopolization are in violation of the New Jersey Anti Trust Act (N.J.S.A. 56:9-1 et seq.).

WHEREFORE, plaintiffs demand:

A) Judgment against defendants in favor of plaintiffs for three times the amount of damages determined to have been sustained by plaintiffs together with the cost of suit, including a reasonable attorney's fee;

B) That the defendants, their present and future officers, directors, employees, agents, successors and assigns, be preliminarily and perpetually enjoined, restrained and prohibited from entering into, adhering to, renewing, maintaining or furthering, directly or indirectly, any like or similar combination and conspiracy to restrain and monopolize trade and commerce of offering group health services in the State of New Jersey.

KRIEGER & CHODASH
Attorneys for plaintiffs

By: /s/ Harold Krieger
HAROLD KRIEGER
A Member of the Firm

JURY DEMAND

Plaintiffs hereby demand a jury of 12 persons as to all issues of plaintiffs' application to proceed in a summary manner is not granted.

KRIEGER & CHODASH
Attorneys for plaintiffs

By: /s/ Harold Krieger
HAROLD KRIEGER
A Member of the Firm

ANSWER FILED BY THE COMMISSIONERS OF HEALTH AND INSURANCE

Defendants, Commissioners of Insurance and Health of the State of New Jersey, answering the Complaint of plaintiffs says:

AS TO THE FIRST COUNT

1. They are without knowledge or information sufficient to form a belief as to the truths of the allegations in paragraphs 26, 27, 28, 29, 30, 31 and 32 and leaves plaintiffs to their proofs.

AS TO THE SECOND COUNT

1. They repeat their answers to the First Count of the Complaint in Answer to paragraph 33 and incorporate the same herein by reference as if they were fully set forth at length.

2. They are without knowledge or information sufficient to form a belief as to the truths of the allegations in paragraphs 34, 35, 36, 37, 38, and 39 and leaves plaintiffs to their proofs.

AS TO THE THIRD COUNT

1. They repeat their answers to the First and Second Counts of the Complaint in answer to paragraph 40 and incorporates the same herein by reference as if they were fully set forth at length.

2. They are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraphs 41, 42, 43, and 44 and leaves plaintiffs to their proofs.

AS TO THE FOURTH COUNT

1. They repeat their answers to the First, Second and Third Counts of the Complaint in answer to paragraph 45

and incorporates the same herein by reference as if they were fully set forth at length.

2. They admit the allegations in paragraph 46.

3. They deny the allegations in paragraphs 47, 48 and 49.

AS TO THE FIFTH COUNT

1. They repeat their answer to the First, Second, Third and Fourth Counts of the Complaint in answer to paragraph 50 and incorporates the same herein by reference as if they were fully set forth at length.

2. They admit the allegations in paragraph 51.

3. They deny the allegations in paragraphs 52, 53 and 55.

4. They are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph

This action is not maintainable because the Complaint fails to state a claim upon which relief can be granted.

RESERVATION OF RIGHT TO MOVE TO DISMISS COMPLAINT

This defendant reserves the right, at or before the trial of this action, to move to dismiss the Complaint for the reason to set forth in his separate defense.

GEORGE F. KUGLER, JR.
Attorney General of New Jersey
Attorney for Defendants,
New Jersey Commissioners of
Insurance and Health

By: /s/ Steven R. Bolson
STEVEN R. BOLSON
Deputy Attorney General

MOTION BY BLUE CROSS FOR SUMMARY JUDGMENT

TO: KRIEGER & CHODASH, ESQS.
Attorney for Plaintiffs
921 Bergen Avenue
Jersey City, New Jersey

SIRS:

PLEASE TAKE NOTICE that on Friday, September 29, 1972, at 9:00 o'clock in the forenoon, or as soon thereafter as counsel may be heard, the undersigned, attorneys for the defendant Hospital Service Plan of New Jersey, will move before the Superior Court, Chancery Division, Hudson County, at the Court House, Jersey City, New Jersey, for Summary Judgment in its favor pursuant to R. 4:46 of the Rules of New Jersey on the ground that there exists no genuine issue as to any material fact and that defendant Hospital Service Plan of New Jersey is entitled to a Judgment in its favor as a matter of law.

PLEASE FURTHER NOTICE that in support of the within motion defendant Hospital Service Plan of New Jersey will rely upon the brief and affidavit submitted by the defendant hospitals in their application for an Order dismissing the Amended and Supplemental Complaint.

PITNEY, HARDIN & KIPP

By: /s/ Clyde A. Szuch
CLYDE A. SZUCH
A Member of the Firm

STATEMENTS

The originals of the within Motion for Summary Judgment and all supporting papers required to be filed have been sent for filing to the Clerk of the Superior Court.

/s/ Ronald E. Wiss
RONALD E. WISS

A clear copy of the within Motion for Summary Judgment together with originals or clear copies, as appropriate, of all supporting papers have been sent for filing to Judge A. Alfred Fink, Court House Administration Building, Jersey City, New Jersey.

/s/ Ronald E. Wiss
RONALD E. WISS

CERTIFICATE OF SERVICE

I hereby certify that on this date copies of the Motion for Summary Judgment were served upon all other counsel of record in this matter by mailing the same, first class mail, postage prepaid, at Newark, New Jersey, addressed to their respective offices:

/s/ Ronald E. Wiss
RONALD E. WISS

DATED: September 22, 1972

HOSPITAL'S MOTION TO DISMISS COMPLAINT

TO: KRIEGER & CHODASH, ESQS.
Attorneys for Plaintiffs
921 Bergen Avenue
Jersey City, New Jersey

SIRS:

PLEASE TAKE NOTICE that on Friday, September 29, 1972, at 9:00 o'clock in the forenoon, or as soon thereafter as counsel may be heard, the undersigned, attorneys for the defendant hospitals listed below, will apply to the Superior Court, Chancery Division, Hudson County, at the Court House, Jersey City, New Jersey, for an Order dismissing the FIRST, SECOND and THIRD Counts of the Amended and Supplemental Complaint its entirety as said defendant hospitals for the reason that said Amended and Supplemental Complaint fails to state a claim upon which relief can be granted against defendant hospitals.

In support of this motion, defendants will rely upon the brief and affidavit submitted herewith.

DATED: September 12, 1972

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AFFIDAVIT OF LESTER M. BORNSTEIN
(Annexed to Foregoing Motion)

STATE OF NEW JERSEY:
SS:
COUNTY OF ESSEX :

LESTER M. BORNSTEIN, of full age being duly sworn upon his oath deposes and says:

1. I reside at 6 Ahern Way, West Orange, New Jersey.

2. I am Executive Director of Newark Beth Israel Medical Center, one of the defendants in Borland et al v. Bayonne Hospital et al and have served as Executive Director of Newark Beth Israel Medical Center since 1968. In my position as Executive Director I am fully familiar with the procedures followed by hospitals which have contracted with New Jersey Blue Cross with respect to the setting of Blue Cross reimbursement rates.

3. In October or November of each year the contracting hospitals prepare and submit proposed operating budgets for the coming calendar year to the Budget and Advisory Committee appointed by the Commissioner of Insurance. The Committee is assisted in its review by the Budget Reviewing Staff, a division of the Hospital Research and Educational Trust of New Jersey.

4. The budgets must be submitted on forms provided by the Commissioner of Insurance. These forms exclude certain items of non-reimbursable costs.

5. On the basis of the budgets submitted the Committee recommends to the Commissioner of Insurance for his approval a tentative per diem reimbursement rate for the operating year for admissions to each hospital. The rate, when approved by the Commissioners of Insurance and

Health, becomes the rate used by New Jersey Blue Cross in its reimbursement for services rendered to subscribers. Neither Blue Cross nor the contracting hospitals has the right to alter the rate established by the Commissioners.

6. At the end of each year the hospitals' results of operations are audited by accountants for New Jersey Blue Cross. In the event that the interim rate resulted in an overpayment based on actual costs incurred by a contracting hospital, an adjustment must be made in favor of Blue Cross. Prior to 1968 a similar adjustment was automatically made in favor of the contracting hospital in the event that the results of the audit showed that the costs exceeded the established interim rate. Since at least 1968, however, the interim rate established by the Commissioners of Health and Insurance has in effect become a ceiling rate with the result that costs in excess of the interim rate may be recovered only if approved by the Commissioners following an appeal by the affected hospital.

/s/ Lester M. Bornstein
LESTER M. BORNSTEIN

NOTARIZED

CERTIFICATION

I HEREBY CERTIFY that the original of the within Notice of Motion to Dismiss Complaint, returnable September 29, 1972, has been filed with the Clerk of the Superior Court of New Jersey, State House Annex, Trenton, New Jersey, and that a clear copy thereof has been filed with The Honorable Alfred A. Fink, at the Court House, Jersey City, New Jersey.

/s/ Dickinson R. Debevoise
DICKINSON R. DEBEVOISE

DATED: September 12, 1972.

CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that a copy of the within Notice of Motion to Dismiss Complaint and Brief in support thereof have been served upon the following at the addresses set forth below by certified mail, return receipt requested, this 12th day of September, 1972:

Krieger & Chodash, Esqs.
921 Bergen Avenue
Jersey City, New Jersey

Hon. George F. Kugler, Jr.
Attorney General of New Jersey
State House Annex
Trenton, New Jersey

Hon. Richard McDonough
Commissioner of Insurance
State House Annex
Trenton, New Jersey

Hon. James R. Cowan
Commissioner of Health
State House Annex
Trenton, New Jersey

Pitney, Hardin & Kipp, Esqs.
Attorneys for Blue Cross
570 Broad Street
Newark, New Jersey

/s/ Dickinson R. Debevoise
DICKINSON R. DEBEVOISE

DECISION IN BORLAND, et al v. BAYONNE HOSPITAL, et al GRANTING BOTH MOTIONS FOR SUMMARY JUDGMENT IN FAVOR OF THE DEFENDANTS

Argued January 5, 1973. Decided

Messrs. Krieger & Chodash, attorneys for plaintiffs, by Mr. Harold Krieger,

Messrs. Smith, Stratton, Wise & Heher, attorneys for defendant, Bayonne Hospital, by Mr. John R. Heher,

Messrs. Lebson & Prigoff, attorneys for defendant, Englewood Hospital Association, by Mr. John F. Fegelein,

Messrs. Morrison & Griggs, attorneys for defendant, Greater Paterson General Hospital, by Mr. Donald W. de Cordova,

Messrs. Winne & Banta, attorneys for defendant, Hackensack Hospital Association, by Mr. Peter G. Banta,

Messrs. Kein, Pollatschek & Iacopino, attorneys for defendant, Irvington General Hospital, by Mr. Vincent J. Iacopino,

Messrs. Breslin & Breslin, atorneys for the defendant, Holy Name Hospital, by Mr. Charles Rodgers,

Messrs. Riker, Danzig, Scherer & Brown, attorneys for defendants, The Hospital Center at Orange and Saint Barnabas Medical Center, by Mr. Dickinson R. Debevoise,

Messrs. Schenck, Price, Smith & King, attorneys for defendant, Morristown Memorial Hospital, by Mr. Clifford W. Starrett,

Messrs. Booth, Bate, Hagoort, Keith & Harris, attorneys for defendant, The Mountainside Hospital, by Mr. David S. Bate,

Messrs. Lowenstein, Sandler, Brochin, Kohl & Fisher, attorneys for defendant, Newark Beth Israel Medical Center, by Mr. Bruce D. Shoulson,

Messrs. Clapp & Eisenberg, attorneys for defendant, Riverdell Hospital, by Mr. Stuart L. Pachman,

Messrs. McCann & McCann, attorneys for defendant, Saddle Brook Hospital, by Mr. Edmund V. McCann,

Messrs. Milton, Keane & Brady, attorneys for defendants, St. Michael's Medical Center and St. Mary's Hospital of Hoboken, by Mr. William F. Tuohey,

Messrs. Johnson, Johnson & Murphy, attorneys for defendant, St. Joseph's Hospital, by Mr. William F. Johnson, Jr.,

Messrs. Mandak, Roth & Ferrante, attorneys for defendant, St. Mary's Hospital of Passaic, by Mr. Frank A. Ferrante,

Mr. George F. Kugler, Jr., Attorney General of New Jersey, attorney for defendants, Commissioner of Insurance and Commissioner of Health, by Mr. Mark L. First, Deputy Attorney General,

Messrs. Pitney, Hardin & Kipp, attorneys for defendant, Hospital Service Plan of New Jersey, by Mr. Clyde A. Szuch,

Mr. Herbert Alterman, attorney for defendant, Beth Israel Hospital,

Mr. Michael J. Ferrara, attorney for defendant, Bergen Pines County Hospital,

Messrs. Smith, Kramer & Morrison, attorneys for defendant, Clara Maas Memorial Hospital,

Messrs. Giordano, Giordano & Halleran, attorneys for defendant, Monmouth Medical Center,

Messrs. Wilentz, Goldman & Spitzer, attorneys for defendant, South Amboy Memorial Hospital.

FINK, J.S.C.

Plaintiffs, Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO (hereinafter "Union"), and Howard Marks, a union member and eligible beneficiary of the union welfare plan, have instituted the within action against twenty-two New Jersey hospitals, the Hospital Service Plan of New Jersey (herein impleaded as "The Blue Cross-Blue Shield Plan of New Jersey"), the New Jersey Commissioner of Insurance and the New Jersey Commissioner of Health.

The suit is filed as a class action on behalf of labor union welfare funds in the State providing medical service benefits not funded through Blue Cross and members of labor unions providing such plans. Plaintiffs seek injunctive relief and damages for alleged discrimination by defendant hospitals in charging plaintiffs higher rates for hospital services than are charged to Blue Cross subscribers for identical service.

The complaint asserts that the differential in rates is illegal and improper in that:

1. It deprives plaintiffs of due process under Article I, Paragraph 1 of the State Constitution;

2. It deprives plaintiffs of equal protection of the laws under the United States and State Constitutions;

3. It constitutes an infringement of the right to bargain collectively contrary to Article I, Paragraph XIX of the State Constitution;

4. It is the end result of a conspiracy between the hospitals and Blue Cross in furtherance of a common plan and mutual scheme in violation of the New Jersey Anti-Trust Act (*N.J.S.A.* 56:9-1 *et seq.*)

Defendant hospitals moved to dismiss the complaint as it applies to them on the ground that the complaint fails to state a cause of action against them. This motion, under *R.* 4:6-2, will be treated as a motion for summary judgment.

Defendant, Hospital Service Plan of New Jersey (hereinafter "Blue Cross") moved for summary judgment on the ground that there exists no genuine issue as to any material fact and that Blue Cross is entitled to a judgment in its favor as a matter of law.

The Commissioner of Insurance and the Commissioner of Health have filed an answer but do not join in these motions.

The right to proceed with this litigation as a class action under *R.* 4:32-1 has not yet been established. The parties have stipulated that the proceedings necessary to establish this litigation as a class action should be held in abeyance until the determination of the pending motions.

The threshold question is whether the matter is ripe for summary judgment as between the plaintiffs, the hospitals and the Hospital Plan of New Jersey.

For the reasons that follow, it is my judgment that the issues involved are legal in nature only.

All of the parties admit that there is such a differential, that is, the plaintiffs, commercial insurance companies, individuals, labor unions and all others, pay for hospital services at higher rates than are prescribed by the Commissioner of Insurance and the Commissioner of Health for reimbursement for services rendered Blue Cross subscribers. At this point, it must be noted that Federal Agencies under the medicare program also pay less by reason of applicable statutory law. *N.J.S.A.* 26:2H-18(b); 42 *U.S.C.A.* Sec. 1395f(b); 20 *CFR*, Sec. 405, 401(a).

Plaintiffs assert that there are fact issues that preclude disposition of the case as to the hospitals and Blue Cross on a summary judgment basis. In their brief, they state:

> "The unknown factual questions which necessitate and warrant discovery stem from the first negotiations between N.J. Hospitals and Blue Cross, whereby a formula is determined and agreed upon between the parties, which is then used to calculate the per diem rate to be charged Blue Cross subscribers *after approval by the Commissioners of Insurance and Health*. The secrecy of these negotiations, and the defendants refusal to stipulate as to these matters has created a factual question which must be exposed by discovery. This factual question is: what specific cost and expense items are excluded or included from the total costs (as required by *NJRS*. 26:2H-4) in arriving at the formula which is used as basis for calculation of the per diem rate charged Blue Cross subscribers, and as a result thereof, fixes the discriminatory rate charged non-Blue Cross subscribers."

Plaintiffs' contention overlooks the fact, however, that neither Blue Cross nor the hospitals control how much Blue Cross reimburses the hospitals for services rendered to Blue Cross subscribers. That function is vested in the Commissioner of Insurance of the State of New Jersey with the approval of the Commissioner of Health of the State of New Jersey by virtue of the Health Care Facilities Planning Act, *N.J.S.A.* 26:2H-18(d). On the other hand, the power and duty to determine charges made to the general public remain vested in the governing bodies of the defendant hospitals. The rate making process under the above Act requires the rate of payment by Blue Cross to participating hospitals to be approved annually. The actual procedure is that in October or November of the preceding year each hospital prepares and submits its proposed operating budget for the coming calendar year to the Budget and Advisory Committee appointed by the Commissioner of Insurance. The Advisory Committee consists of three physicians, five hospital administrators, and four hospital trustees. The Committee is assisted in its review by the Budget Review Staff, a division of the Hospital Research and Educational Trust of New Jersey. The Health Care Facilities Planning Act requires the Commissioner of Health, in consultation with the Commissioner of Insurance, to determine and certify the costs of providing health care services based on reports prepared by the hospitals in accordance with a uniform system of cost accounting. (*N.J.S.A.* 26:2H-18(c)).

The Committee recommends to the Commissioner for his approval a tentative per diem reimbursement rate for the operating year for admissions to each hospital.

It is conceded by the hospitals and Blue Cross that in computing reimbursement rates by Blue Cross the

Commissioners of Insurance and Health omit from consideration some of the costs necessary to the operation of hospitals (e.g. the cost of providing indigent care). As a result the rates hospitals charge others, including plaintiffs, is computed to permit the hospitals to recapture their omitted costs. The difference in rates is said to approximate twenty per-cent.

Thus the alleged questions of fact are not questions of fact at all. The hospitals and Blue Cross concede that the reimbursement rate paid by Blue Cross for services rendered to subscribers is less than the rates paid by plaintiffs and others, and they also concede the method by which those different rates are established. Their response, however, is that they do not control the ultimate reimbursement rate paid by Blue Cross; that this is the sole function of the Commissioners of Insurance and Health, and that plaintiffs' complaints against them are misdirected.

In the face of the admission by the hospitals and Blue Cross that some items of cost are omitted by the Commissioners of Insurance and Health in calculating the reimbursement rate, I see no necessity for a plenary hearing to determine the precise item or items of cost that are omitted from consideration by the Commissioners of Insurance and Health. That may become necessary in the remaining part of the action against the Commissioners of Insurance and Health. *N.J.S.A.* 26:2H-18(d) provides that in establishing such rates the Commissioners shall take into consideration the total costs of the hospitals. In actual practice, the form on which each hospital must submit its budget is provided by the Commissioner of Health. Such forms exclude certain items of non-reimbursible costs based on policy decisions made by the Commissioners of Health and Insurance, and this generally accounts for the difference between the reimbursement rates paid by Blue Cross and the hospital established rates to non hospital service corporations. Whether such omissions are in violation of the provisions of *N.J.S.A.* 26:2H-18(d) is, however, not an issue as between plaintiffs and the hospitals and Blue Cross. In fact, it is an issue which the hospitals themselves, in their brief, have reserved the right to raise at an appropriate time and in an appropriate proceeding. Insofar as the present litigation is concerned, the omission of costs is an issue as between the plaintiffs and the Commissioners of Health and Insurance.

Based upon the assumption that under the Health Care Facilities Act, *N.J.S.A.* 26:2H-1 *et seq.*, reimbursement rates to Blue Cross for service to its subscribers may be at a rate which is less than that charged to others, the hospitals and Blue Cross take the position that that is constitutionally permissible. The plaintiffs take the position that this is constitutionally impermissible. It is that issue, among others, that will occupy the attention of this Court in this opinion.

As to the allegations levelled by plaintiffs at the hospitals and Blue Cross involving "secret negotiations," "mutual schemes" and "conspiracy" to fix the rates Blue Cross pays, they are just that, namely, bare allegations. There is not a single pleaded fact to support them. In my opinion they are spurious and warrant no consideration.

THE CONSTITUTIONAL ISSUES ARISING UNDER THE DUE PROCESS CLAUSE OF THE NEW JERSEY CONSTITUTION AND THE EQUAL PROTECTION CLAUSE OF THE FEDERAL CONSTITUTION.

Plaintiffs allege a violation of their rights to due process under Article I, Paragraph 1 of the New Jersey Constitution and to equal protection under Section 1 of the Fourteenth Amendment of the United States Constitution.

"While due process and equal protection guarantees are not coterminous in their spheres of protection, equality of right is fundamental in both. Each forbids class legislation arbitrarily discriminating against some and favoring others in like circumstances." *Washington National Insurance Company v. Board of Review*, 1 *N.J.* 545 (1949).

Discrimination and inequality of rights are plaintiffs' sole complaints. Since those complaints invoke the same principles involving due process under the State Constitution, and equal protection under the Federal Constitution, they will be discussed under one heading.

Specifically, plaintiffs allege that the hospitals and Blue Cross illegally discriminate against them in violation of their constitutional rights in that the hospitals charge Blue Cross less for services rendered its subscribers than is charged to plaintiffs for identical services rendered to its members.

In challenging the rates paid by Blue Cross, plaintiffs are in effect challenging the constitutionality of the Hospital Service Corporation Act.

Not every inequality offends the constitutional provision of due process and equal protection. *Lindsley v. Natural Carbonic Gas Co.*, 220 *U.S.* 61, 78-79 (1911); *Dandridge v. Williams*, 397 *U.S.* 471, 485 (1970). See also, *David v. Vesta Co.*, 45 *N.J.* 301, 315 (1965).

The requirement of equal protection is satisfied if all persons within a class reasonably selected are treated alike. And a classification is reasonable if it rests upon some grounds of difference having a real and substantial relation to the basic object of the particular enactment or on some relevant consideration of public policy. If there is a reasonable distinction, there is no oppressive discrimination.

The Legislature has a wide range of discretion in this area and distinctions wil be presumed to rest upon a rational basis if there be any conceivable state of facts which would afford reasonable support for them. *Robson v. Rodriquez*, 26 *N.J.* 517 (1958); *Wilson v. Long Branch*, 27 *N.J.* 360 (1958).

Hence, in assailing the statutory scheme which compels the present difference in rates on the grounds that it violates the equal protection and due process clauses of the Fourteenth Amendment, plaintiffs must carry the burden of showing that the classification which results in favorable benefits to hospital service corporations such as Blue Cross does not bear a reasonable relation to a permissible legislative objective. *West Coast Hotel Co. v. Parrish*, 300 *U.S.* 379, 391 (1937), and is essentially arbitrary. *Goldblatt v. Hempstead*, 369 *U.S.* 590 (1962); *Lindsley v. Natural Carbonic Gas Co.*, 220 *U.S.* 61, 78-79 (1911); *Independent Elec. & Elec. Contractors' Assoc. of N.J. v. N.J. Bd. of Exam. of Elec Cont.*, 54 *N.J.* 466, 473 (1969); *David v. Vesta Co.*, 45 *N.J.* 301, 314-315 (1965). If any state of facts reasonably may be conceived to justify the distinction, the statute will be upheld. *Dandridge v. Williams*, 397 *U.S.* 471, 486-87 (1970); *Metropolitan Casualty Ins. Co. v. Brownell*, 294 *U.S.* 580 (1935).

The state has unquestioned power to legislate in the area of public health. *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 *U.S.* 483 (1955). This is especially so regarding the modern hospital system which is operated for the benefit of the public. See *Griesman v. Newcomb Hospital*, 40 *N.J.* 389, 396 (1963). Equally clear is the fact that, at least in the field of insurance, "the power of the state is broad enough to take over the whole business, leaving no part for private enterprise." *California State Auto. Assoc. Inter-Ins. Bureau v. Maloney*, 341 *U.S.* 105, 110 (1951);

Osborn v. Ozlin, 310 *U.S.* 53 (1940). Not only may the state completely preempt the field of health insurance, but it may affirmatively require the purchase of insurance or its equivalent. *New York Central R. Co. v. White*, 243 *U.S.* 188, 208-09 (1917) (Workmen's Compensation). Alternatively, the state may enact compulsory health insurance supported by employer contributions or by taxes. *See generally, Falk, "National Health Insurance; A Review of Policies and Proposals,"* 37 *L. & Contemp. Prob.* 669 (1970); *Falk, "Beyond Medicare,"* 59 *A.M. J. Pub. Health* 608 (1969). *Cf. Mountain Timber Co. v. Washington*, 243 *U.S.* 219 (1917) (contribution to state fund for Workmen's Compensation).

In New Jersey, rather than preempt the health insurance field entirely, cf. *Independent Service Corp. v. Tousant*, 56 *F. Supp.* 75 (D. Mass. 1944), aff'd 149 *F.2d* 204 (1st Cir. 1945), the Legislature has chosen to enact the Hospital Service Corporation Act (*N.J.S.A.* 17:48-1 *et seq.*) which is designed particularly to accomplish the purpose of a broad based community health program, *i.e.*, to satisfy the needs of the hospitals and the community as a whole through a partnership between hospitals and a non-profit prepayment plan. See *Associated Hospital Service, Inc. v. Milwaukee*, 13 *Wis. 2nd* 447, 109 *N.W. 2d* 271 (Sup. Ct. 1961); *cf. Johnson v. Hospital Service Plan of N. J.*, 25 *N.J.* 134 (1957). *See generally, Report of Special Counsel to the Commissioner of Banking and Insurance of the State of New Jersey For The Public Interest* 30-32 (1970) *(Wharton Report); Final Report of the New Jersey Commission appointed by the Governor to Study Blue Cross in New Jersey* (1967) *(Ward Report); Final Report of the New Jersey Blue Cross Rate Study Commission* 28-30 (1960) *(Simon Report)* ("The basic philosophy of Blue Cross has always been that of constant progress toward the goal of

complete protection against the unpredictable costs of hospital services for all the people of the community".) The goals and objectives of this partnership are (a) to provide to the public a payment-in-advance method for financing care provided by hospitals and to guarantee payment to the hospitals; (b) to make hospital care needed by the public financially accessible to the largest number of people at the lowest possible cost; and (c) to help the community carry the social and economic burden created when people are unable to pay for the necessary care rendered by hospitals. *See generally, Wharton Report* 30-32 (1970). *Johnson v. Hospital Service Plan of N.J.* 25 *N.J.* 134, 144 (1957).

The relationship of the legislative program to these goals is readily apparent from the statutory provisions of the Hospital Service Corporation Act and companion legislation. So, for example, in order to maintain low cost to the public, the statute requires that a hospital service corporation be organized without capital stock and not for profit (17:48-1); that it be operated only for the benefit of its subscribers (17:48-2); that it be strictly limited as to expenditures for solicitation and administration (17:48-10); that its reserves be kept low in contrast to commercial carriers (compare 17:48-10 with 17B:19-5); that its investments be strictly limited (17:48-10); and that it be exempt from most taxes (17:48-18).

When the Hospital Service Corporation Act is read together with the recently enacted Health Care Facilities Planning Act, there emerges an integrated program combining Blue Cross with the entire apparatus for the control of hospital costs under the Commissioners of Health and Insurance. Section 1 of the new Act states:

> "It is hereby declared to be the public policy of the State that hospital and related health care services

> of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health." (*N.J.S.A.* 26: 2H-1)

It is under this Act that the Commissioners of Health and Insurance are given power to determine a "reasonable" rate of reimbursement for the hospitals (*N.J.S.A.* 26:2H-18).

In contrast to the statutorily created tripartite program involving the Commissioners of Insurance and Health, Blue Cross, and the hospitals, commercial health insurance carriers operate for profit and charge whatever premiums and pay whatever benefits they choose subject only to the requirement that benefits to individual subscribers are not unreasonable in relation to the premium charged (17B:26-1 (h) 1). Moreover, a commercial carrier has great freedom to experience rate its group customers, and unlike a hospital service corporation, it is not limited in its right to terminate coverage.

Plaintiff trustees do not constitute either a hospital service corporation or an insurance company. Hence, they are not subject to the strict regulatory statutory controls imposed on hospital service corporations or even to the looser regulations governing insurance companies. They provide benefits to members subject only to general fiduciary principles. Most importantly, the goals and objectives of the plaintiff trustees are not to provide prepayment of hospital care for the community at large or to help the community carry the social and economic burden of such care. Nor is it their function to guarantee payment or insure its prompt receipt by the hospitals. See *Johnson v. Hospital Service Plan of N. J.* 25 *N.J.* 134 (1957).

In *Associated Hospital Service, Inc. v. Milwaukee,* 13 *Wis.* 2d. 447, 109 *N.W.* 2d 271, 88 *A.L.R.* 2d. 1395 (1961),

the Wisconsin Supreme Court considered whether the tax exemption granted the Blue Cross plan resulted in an unreasonable classification violative of the equal protection clause of the Fourteenth Amendment. In particular, the City of Milwaukee argued that an arbitrary and unconstitutional classification is made by the statute in granting exemption to the property of Blue Cross and not that of insurance companies. The court, after discussing the history and background of Blue Cross and the purposes and objectives to which it is dedicated, noted the "marked difference in method of operation between a Blue Cross hospital service corporation and a commercial insurance company that sells hospital care indemnity insurance." 88 *A.L.R.* 2d. at 1411. The court said:

> "The state's interest in protecting the financial status of its state, county, municipal, and voluntary non-profit hospitals is a further justification for treating Blue Cross hospital service corporations differently tax wise than it does commercial insurance companies writing hospital care indemnity insurance." 88 *A.L.R.* 2d. at 1412.

The court concluded:

> "Enough has been said to indicate that the classification made by (the statute) does rest upon real differences existing between non-profit hospital service corporations and commercial insurance companies writing hospital care indemnity insurance. Therefore, such statute does not impose an arbitrary unreasonable classification and is constitutional." Id.

For purposes of this motion it may be assumed *arguendo* that plaintiff trustees, in attempting to provide a health service benefits program to members of the union, are at a

. .

competitive disadvantage vis a vis Blue Cross to the extent that the latter pays less per patient than the plaintiff trustees. However, given the public and quasipublic nature of the entire hospital service corporation system—especially the Blue Cross-member hospital relationship as controlled and regulated by the Commissioners of Health and Insurance—it is apparent that the trustees are complaining of an unequal competitive environment created by and maintained by the state. No constitutional doctrine requires that the state permit free competition or eschew competing with private concerns especially in an area of such public concern as health financing for the community. *Cf. Tennessee Electric Power Co. v. T.V.A.*, 306 *U.S.* 118, 138-40 (1939) (private utility complains of T.V.A. competition and TV.A.'s ability to offer lower rates); *Medera Water Works Co. v. Helena*, 195 *U.S.* 383, 388 (1904); *Joplin v. Southwest Missouri Light Co.*, 191 *U.S.* 150 (1903). *Cf. Hardin v. Kentucky Utility Co.*, 390 *U.S.* 1 (1968) (T.V.A. competition). Indeed, the Government can permit or even destroy such competition. *Missouri Utilities Co. v. California*, 8 *F. Supp.* 454, 465 (W.D. Mo. 1934), appeal dismissed 79 *F. 2d.* 1003 (8th Cir. 1935).

Notwithstanding its power to do so, in creating hospital service corporations and in regulating their reimbursement of hospitals, the State of New Jersey has not sought to forbid or destroy competition among other organizations wishing to provide health insurance or health service benefits. Neither has the state required all persons to purchase Blue Cross insurance or forbidden others to act as third party payors. Rather the statute creating the Blue Cross program provides certain benefits to and imposes certain burdens on Blue Cross so as to enable it to accomplish its statutory purposes. The fact that in so doing the plaintiff trustees' welfare plan has been put at a competitive disadvantage does no violence to the Constitution. *Cf. Independent Service Corp. v. Tousant*, 56 *F. Supp.* 75 (D. Mass. 1944), aff'd. 149 *F. 2d.* 204 (1st Cir. 1945). See also *Virgo Corp. v. Paiewonsky*, 384 *F. 2d* 569 (3d Cir. 1967), *cert denied* 390 *U.S.* 1041 (1968) (one of four competitors may be denied subsidies granted to others where, in view of public purpose of subsidy program, classification was not "patently arbitrary").

THE CONSTITUTIONAL ISSUE ARISING UNDER ARTICLE I, PARAGRAPH 19 OF THE NEW JERSEY CONSTITUTION WHICH GUARANTEES THE RIGHTS OF EMPLOYEES TO ORGANIZE AND BARGAIN COLLECTIVELY.

The pertient part of the constitutional provision referred to above states:

> "Persons in private employment shall have the right to organize and bargain collectively".

Plaintiffs assert that their right to organize and bargain collectively has been infringed upon but how it has been infringed upon by the hospitals and Blue Cross is not explained. In my judgment, the constitutional guarantee of the right of persons in private employment to organize and bargain collectively has no application to the dispute between the parties in this case. The relationship of employer and employee does exist between the hospitals, Blue Cross and the plaintiffs. The gravamen of a right to collective bargaining rests upon an employee-employer relationship. Compare *Johnson v. Christ Hospital*, 84 *N.J. Super.* 541 (Ch. Div. 1964), aff'd. 45 *N.J.* 108 (1965).

Neither the industry of counsel nor of this Court has turned up a case in New Jersey or in Federal Law whereby a third party not involved in labor negotiations has been

held bound by the provisions of Article I, Paragraph 19 of the New Jersey Constitution.

THE NEW JERSEY ANTI-TRUST ACT, *N.J.S.A.* 56:9-1, *et seq.* HAS NO APPLICATION IN THIS CASE.

Section 3 of the above Act provides:

"Every contract, combination in the form of trust, or otherwise, or conspiracy in restraint of trade or commerce in this State shall be unlawful".

Plaintiffs assert:

"The defendant hospitals have conspired with the officers, employees and directors of Blue Cross in furtherance of a common plan and a mutual scheme in violation of the New Jersey Anti-Trust Act in charging the plaintiffs and members of all other welfare unions similarly situated more than subscribers of defendant Blue Cross are required to pay for the same equipment, facilities and services, thereby depriving plaintiff and members of their class of their property by reason of such acts, consipracy, common plan, mutual scheme and monopolization in violation of the provisions of the New Jersey Anti-Trust Law".

The New Jersey Anti-Trust Act, *N.J.S.A.* 56:9-12 also provides:

"(a). Any person who shall be injured in his business or property by reason of a violation of the provisions of this act may sue therefor and shall recover threefold the damages sustained by him, together with reasonable attorneys' fees, filing fees and reasonable costs of suit. Reasonable costs of suit may include, but shall not be limited to the expenses of discovery and document reproduction".

Based upon the authority of the above section, the plaintiffs for themselves and for each member of the contemplated class seek treble damages together with reasonable attorneys' fees, filing fees and reasonable costs of suit.

In my judgment, the New Jersey Anti-Trust Act has no application in this controversy for the following reasons:

(1) I have heretofore pointed out that plaintiffs allege no facts to support their contention that the defendant hospitals have conspired with the officers, members and directors of Blue Cross in furtherance of a common plan, a mutual scheme and monopolization in violation of the New Jersey Anti-Trust Act. Plaintiffs charge conspiracy but tacitly admit that the charge is based upon no known facts. In plaintiffs' brief, reference is made to "the unknown factual questions" which necessitate and warrant discovery and stem from the first negotiations between New Jersey hospitals and Blue Cross whereby a formula is determined and agreed upon between the parties which is then used to calculate the per diem rate to the charged Blue Cross subscribers *after approval by the Commissioners of Insurance and Health.*

Even assuming, as plaintiffs charge, that a formula is determined and agreed upon between the parties which is then used to calculate the per diem rate to be charged Blue Cross subscribers *after approval by the Commissioners of Insurance and Health*, it is not conceivable how those negotiations and the resultant formulas in which the State of New Jersey, through the Commissioner of Insurance and the Commissioner of Health participates, constitute a violation of the New Jersey Anti-Trust Act.

(2) The Anti-Trust Act provides that:

"*Charitable Exemption:* 'No provisions of this Act shall be construed to make illegal:

• • •

"'(5) The bona fide religious and charitable activities of any not for profit corporation . . . established exclusively for religious or charitable purposes, or for both purposes'". *N.J.S.A.* 56:9-5(b)

All but one of the defendant hospitals come within this class of organization.

Plaintiffs' brief offers no reason or authority to support its bare statement that defendant hospitals should be denied the exemption for which the statute specifically provides.

(3) *Insurance Exemption.* Blue Cross and the rate of Blue Cross reimbursement to hospitals are subject to detailed regulation by the Commissioner of Insurance. As such, the establishment of the payment rates to which plaintiffs object is exempt from New Jersey's Anti-Trust Act, which provides:

"No provisions of this Act shall be construed to make illegal:

• • •

"(4) The activities . . . of any insurer . . . to the extent that such activities are subject to regulation by the Commissioner of Insurance of this State under, or are permitted, or are authorized by, the Department of Banking and Insurance Act of 1948 (C. 17:1-1 et seq.) and the Department of Insurance Act of 1970 (C. 17:1C-1 et seq.)" *N.J.S.A.* 56:9-5(b)(4).

Plaintiffs argue that Blue Cross is not an "insurer" within the meaning of this exemption, citing cases which define

"insurer" in contexts outside of the anti-trust field and which, therefore, are not pertinent.

The determination of whether or not Blue Cross is an insurer within the meaning of the Anti-Trust Act exemption must be determined in light of the purpose of the exemption. Clearly the exemption is designed to avoid the situation whereby a state regulatory agency acting pursuant to one statute (the insurance laws) requires conduct which might be held to violate another statute (the Anti-Trust Act).

With the purpose of the anti-trust exemption language in mind, the cases follow a consistent pattern. In that context, Blue Cross organizations regulated by an insurance commissioner are deemed to be insurers and exempt from anti-trust provisions.

To hold otherwise would be contrary to established principles of statutory construction, for then acts which the Commissioner is authorized and directed to perform under *N.J.S.A.* 17:48-1, *et seq.*, regulating hospital service corporations would be prohibited by *N.J.S.A.* 56:9-1, *et seq.* A statute is not to be construed in such a way that it will render other legislative acts vain or impotent. *State v. McCall,* 14 *N.J.* 538, 103 *A. 2d.* 376 (1954); *Loftus v. Public Service Interstate Transp. Co.,* 26 *N.J. Misc.* 246, 59 A 2d. 652 (Sup.Ct. 1948).

Even without a specific exemption for insurers, the Wisconsin Supreme Court held that Wisconsin Blue Cross, which received a discount from contracting hospitals, did not violate the state anti-trust laws. The Court reasoned that the federal "rule of reason" test should be used in construing the Wisconsin Anti-Trust Law because it had previously been held that the state law was a re-enactment of the Sherman Act for intrastate transactions. Applying

the rule of reason test, the Court held that to violate the state anti-trust law the alleged restraint on trade must be unreasonable, and the restraint in this case was not unreasonable because it was authorized by state laws which clearly fulfilled the legislative intent behind their enactment. *Reese v. Associated Hospital Service, Inc.*, 45 *Wisc.* 2d. 526, 173 (N.W. 2d. 661 (Supp. Ct. 1970).

The application of the McCarren Act, 15 *U.S.C.A.* Sec. 1011-1015, to hospital service corporations compels the conclusion that such a corporation is an "insurer" for the purpose of exemption provisions of anti-trust laws and the contracts establishing hospital reimbursement rates are entered into in the course of an insurer's business.

The McCarren Act provides that the business of insurance and the persons engaged therein shall be subject to the laws of the several states which regulate such business and that the federal anti-trust laws shall be applicable to the business of insurance only to the extent that such business is not regulated by state law (except that the Sherman Act shall continue to apply to boycotts, coercion and intimidation).

In *Traveler's Insurance Co. v. Blue Cross of Western Pa.*, CCH Trade Reg. Rep. Para. 73, 811 (W.D.Penna. 1972) plaintiff insurance company sued Blue Cross under the federal anti-trust laws. The facts were very similar to those in the present case. The hospitals under contract with Blue Cross charged plaintiff and other commercial carriers an average of 14% more for their services than they accepted as full payment from Blue Cross. The activities of Blue Cross, including the contracts for reimbursement, were regulated by the Pennsylvania Insurance Department pursuant to statute.

Blue Cross claimed that it was in the business of insurance and therefore exempt from the federal anti-trust laws by virtue of the McCarren Act. Agreeing with this position, the Court stated:

> ". . . The Blue Cross hospital contract is, therefore, an integral part of Pennsylvania's regulated hospital plan. By reason of the interrelationship of hospital payments and Blue Cross subscriber rates the contract also falls within the ambit of 'insurance business'".

Further, Blue Cross denied that it had engaged in any acts which constituted monopolization or restraint of trade within the meaning of the Sherman Act. As in the present case, the heart of the plaintiff's case was the "discriminatory price advantage emanating from Blue Cross' contract with hospitals". The Court held not only that Blue Cross was exempt from the anti-trust act by virtue of the McCarren Act, it also held that in any event there was no restraint of trade or monopolization in violation of the Sherman Anti-Trust Act.

Motion for Summary Judgment in favor of the defendant hospitals, and the Hospital Service Plan of New Jersey (Blue Cross), is granted.

ORDER FOR SUMMARY JUDGMENT
(Filed March 12, 1973)

This matter having been brought before the court by the defendant hospitals upon a motion to dismiss the complaint as to them, which motion, in accordance with R. 4:6-2, has been treated as a motion for summary judgment, and by the defendant Hospital Service Plan of New Jersey upon motion for summary judgment in said defendant's favor against plaintiffs; and the court having read and considered the affidavits and briefs filed by the defendant hospitals and by the plaintiffs, and the court having heard and considered the arguments of counsel; and the court having rendered an opinion on January 22, 1973; and it appearing to the court that there are no genuine issues as to any material facts and that defendant hospitals and defendant Hospital Service Plan of New Jersey are entitled to judgment against plaintiffs on defendants' motions for summary judgment, as a matter of law; and the court having determined that there is no just reason for delay; and good cause appearing;

IT IS on this 9th day of March, 1973 ORDERED that the motions for summary judgment in favor of defendant hospitals and defendant Hospital Service Plan of New Jersey be and they hereby are granted and final judgment be and hereby is rendered and directed to be entered in favor of defendant hospitals and defendant Hospital Service Plan of New Jersey against plaintiffs with prejudice.

/s/ Alfred A. Fink
ALFRED A. FINK, J.S.C.

NOTICE OF APPEAL TO APPELLATE DIVISION

TO: Judge A. Alfred Fink
Superior Court
Hudson County
Chancery Division
Administration Building
595 Newark Avenue, Jersey City, N.J. 07306

SMITH, STRATTON, WISE & HEHER, Esqs.
Attorneys for Defendant Bayonne Hospital
1 Palmer Square, Princeton, N.J.

HERBERT ALTERMAN, Esq.
Attorney for Defendant Beth Israel Hospital
663 Main Avenue, Passaic, N.J.

LEBSON & PRIGOFF, Esqs.
Attorneys for Defendant Englewood Hospital Association
39 Park Place, Englewood, N.J.

WINNE & BANTA, Esqs.
Attorneys for Defendant Hackensack Hospital Association
25 East Salem Street, Hackensack, N.J.

MICHAEL J. FARRARA, Esq.
Attorney for Defendant Bergen Pines County Hospital
166 Main Street, Hackensack, N.J.

SMITH, KRAMER & MORRISON, Esqs.
Attorneys for Defendant Clara Maass Memorial Hospital
810 Broad Street, Newark, N.J.

MORRISON & GRIGGS, Esqs.
Attorneys for Defendant Greater Paterson General Hospital Association
210 Main Street, Hackensack, N.J.

BRESLIN & BRESLIN, Esqs.
Attorneys for Defendant Holy Name Hospital
41 Main Street, Hackensack, N.J.

RIKER, DANZIG, SCHERER & BROWN, Esqs.
Attorneys for Defendants The Hospital Center at Orange and Saint Barnabas Medical Center
744 Broad Street, Newark, N.J.

GIORDANO, GIORDANO & HALLERAN, Esqs.
Attorneys for Defendant Monmouth Medical Center
Highway 35, Middletown, N. J.

BOOTH, BUERMANN & RATE, Esqs.
Attorneys for Defendant Mountainside Hospital
31 Park Street, Montclair, N.J.

CLAPP & EISENBERG, Esqs.
Attorneys for Defendant Riverdell Hospital
744 Broad Street, Newark, N.J.

WILENTZ, GOLDMAN & SPITZER, Esqs.
Attorneys for Defendant South Amboy Memorial Hospital
252 Madison Avenue, Perth Amboy, N.J.

JOHNSON, JOHNSON & MORPHY, Esqs.
Attorneys for Defendant St. Joseph's Hospital
401 Wanaque Avenue, Pomptom Lakes, N.J.

KEIN, POLLATSCHEK & IACOPINO, Esqs.
Attorneys for Defendant Irvington General Hospital
1000 Stuyvesant Avenue, Union, N.J.

SCHENCK, PRICE, SMITH & KING, Esqs.
Attorneys for Defendant Morristown Memorial
10 Washington Street, Morristown, N.J.

LOWENSTEIN, SANDLER, BROCHIN, KOHL & FISHER, Esqs.
Attorneys for Defendant Newark Beth Israel Medical Center
744 Broad Street, Newark, N.J.

JOHN F. McCANN, Esq.
Attorney for Defendant Saddle Brook Hospital
291 Main Street, Ridgefield, N.J.

MILTON, KEANE & BRADY, Esqs.
Attorneys for Defendants St. Michael's Medical Center and St. Mary's Hospital of Hoboken
40 Journal Square, Jersey City, N.J.

MANDAK, ROTH & FERRANTE, Esqs.
Attorneys for Defendant St. Mary's Hospital of Passaic
415 Clifton Avenue, Clifton, N.J.

STEPHEN R. BOLSON
Deputy Attorney General of New Jersey
Attorney for Defendants New Jersey Commissioners of Insurance & Health
State House, Trenton, N.J. 08625

PITNEY, HARDIN & KIPP, Esqs.
Attorneys for Defendant Hospital Service Plan of New Jersey
570 Broad Street, Newark, N.J. 07102

SIRS:

Notice is hereby given that Plaintiff, John Borland, Jr., et al., appeals to the Appellate Division of the Superior

Court of New Jersey, from the Final Judgment of the Superior Court, Hudson County, Chancery Division (Judge A. Alfred Fink) entered only in favor of the Defendant, Hospital Service Plan of New Jersey, and the Defendant Hospitals in this action, on March 9th, 1973.

The Plaintiff has ordered a copy of the transcript on January 5th, 1973, the original having been filed with the Superior Court.

KRIEGER & CHODASH
Attorneys for Plaintiff

By: /s/ Harold Krieger
HAROLD KRIEGER

DATED: April 13, 1973

NOTICE OF MOTION OF COMMISSIONERS OF HEALTH AND INSURANCE TO TRANSFER THE CASE TO THE APPELLATE DIVISION

SIRS:

PLEASE TAKE NOTICE that on Friday, June 29, 1973, at 9:00 A.M., or as soon thereafter as counsel may be heard, the undersigned attorney for defendants, Richard C. McDonough and James R. Cowan, will make application to the Superior Court of New Jersey, Chancery Division, sitting in Jersey City, at the Court House Administrative Building, Jersey City, New Jersey for an order transferring this matter to the Appellate Division on the grounds that this matter concerns an appeal from a final determination by an administrative agency, which is appealable as of right to the Appellate Division.

TAKE FURTHER NOTICE that in support of the within Motion, the undersigned shall rely upon the brief submitted herewith.

GEORGE F. KUGLER, JR.
Attorney General of
New Jersey
Attorney for Defendants

By: /s/ Steven R. Bolson
STEVEN R. BOLSON
Deputy Attorney General

Dated: June 5, 1973

STATEMENTS

The originals of the within Motion to Transfer the Case to the Appellate Division have been sent for filing to the Clerk of the Superior Court.

s/ Steven R. Bolson
STEVEN R. BOLSON

A clear copy of the within Motion to Transfer the Case to the Appellate Division has been sent for filing to Judge Alfred A. Fink, Court House Administration Building, Jersey City, New Jersey.

s/ Steven R. Bolson
STEVEN R. BOLSON

CERTIFICATE OF SERVICE

I hereby certify that on this date copies of the Motion to Transfer the Case to the Appellate Division were served upon all other counsel of record in this matter by mailing same, first class mail, postage prepaid, at Trenton, New Jersey, addressed to their respective offices.

s/ Steven R. Bolson
STEVEN R. BOLSON

Dated: June 5, 1973

ORDER TO TRANSFER TO APPELLATE DIVISION

This matter being opened to the Court by George F. Kugler, Jr., Attorney General of New Jersey (by Steven R. Bolson, then Deputy Attorney General, on the brief and by Omer F. Brown, II, Deputy Attorney General appearing,) attorney for defendants Richard C. McDonough, Commissioner of Insurance and James R. Cowan, Commissioner of Health, and the Court having examined the briefs of defendant Commissioners and of plaintiffs filed herein and heard the arguments of counsel for defendant commissioners and for plaintiffs, and good cause appearing therefore,

IT IS on this 19th day of October, 1973,

ORDERED:

That this cause of action be transferred to the Appellate Division of the Superior Court in accordance with R. 1:13-4 (a) by virtue of R. 2:2-3 (a).

/s/ Sidney M. Schreiber
SIDNEY M. SCHREIBER,
J.S.C.

ORDER OF THIS COURT FOR REMAND ENTERED JANUARY 22, 1974

(Filed January 24, 1974)

Moving Papers Filed–December 26, 1973
Answering Papers Filed–January 7, 1974
Date Submitted to Court–January 8, 1974
Date Argued–
Date Decided–January 22, 1974

ORDER

This matter having been duly presented to the Court, it is hereby ORDERED as follows:

Motion for Taking of Depositions
Granted Denied X Other X

SUPPLEMENTAL:

(1) The motion to take depositions is denied.

(2) The matter is remanded to the Commissioner of Insurance for the purpose of expanding the record particularly with respect to the method used and the factors considered by him in establishing the rates payable by the Hospital Service Plan of New Jersey (Blue Cross and Blue Shield), as required by *N.J.S.A.* 26:2H-18. When completed the same shall be filed as part of the record on this appeal.

I hereby certify that the foregoing is a true copy of the original on file in my office.
Mortimer E. Newman, Jr., Clerk

FOR THE COURT:
/s/ Joseph Halpern
P.J.A.D.

Witness, the Honorable Joseph Halpern, Presiding Judge of Part E, Superior Court of New Jersey, Appellate Division, this 22nd day of January 197 .

ORDER OF THIS COURT DATED JULY 8, 1974 TO HAVE COMMISSIONERS COMPLY WITH PRIOR ORDER ENTERED JANUARY 22, 1974

(Filed July 11, 1974)

Moving Papers Filed–June 17, 1974
Answering Papers Filed–June 27, 1974
Date Submitted to Court–July 3, 1974
Date Argued–
Date Decided–July 8, 1974

ORDER

This matter having been duly presented to the court, it is hereby ordered as follows:

Motion to Comply with Order of January 22, 1974
Granted– Denied– OtherX

SUPPLEMENTAL:

The Commissioner of Insurance shall comply with our order of January 24, 1974, on or before September 9, 1974.

I hereby certify that the foregoing
is a true copy of the original on file
in my office.

/s/ Elizabeth McLaughlin
Clerk

FOR THE COURT:
/s/ John W. Fritz
JOHN W. FRITZ, P.J.A.D.

Witness, the Honorable John W. Fritz, presiding Judge of part N, Superior Court of New Jersey, Appellate Division, this 8th day of July, 1974.

/s/ Elizabeth McLaughlin
Clerk of the Appellate Division

PLAINTIFF'S MOTION TO ORDER THE COMMISSIONERS TO COMPLY WITH THE TWO ORDERS OF THIS COURT

TO: GEORGE F. KUGLER, JR.
Attorney General of New Jersey
Attorney for Defendants-Respondents
State House Annex
Trenton, New Jersey 08625

SIR:

PLEASE TAKE NOTICE that the plaintiff-appellant now makes application to this Court for an Order requiring the Commissioner of Insurance, James J. Sheeran, to comply with the Order made by this Court on the 22nd day of January, 1974, copy of which is attached hereto and marked Exhibit "A", as reaffirmed by the Order of this Court dated July 8, 1974, wherein the Court Ordered that "the Commissioner of Insurance shall comply with our Order of January 24, 1974", on or before September 9, 1974, a copy of which is attached hereto and is marked as Exhibit "B".

More particularly, the plaintiffs-appellants feels that the "EXPANSION OF THE RECORD ON REMAND" is defective and/or defecient in the following respects:

1. The material furnished did not indicate how the final limitation on the amount of per diem payable by Blue Cross was established.

2. There is no explanation or justification given for item G(e) appearing on page 18(a).

3. There is no explanation for the limitation on the amount of expense absorbed by Blue Cross relating to computer operations.

4. The expanded record is obscure as to the extent that bad debts are included in the total costs upon which Blue Cross payments are made.

5. There is no explanation of why non-Blue Cross non-governmental per diem charges exceed Blue Cross by approximately 20%, when *N.J.S.A.* 26:2H-18 dictates that *all costs* must be included in the Blue Cross rates.

6. The "EXPANSION OF THE RECORD ON REMAND" is defective in form inasmuch as it does not state findings of fact or conclusions of law as made by the Commissioner.

This Motion is supported by the attached Affidavit and Memorandum.

Respectfully submitted,
KRIEGER & CHODASH
By: /s/ Harold Krieger
HAROLD KRIEGER

Dated: December 16, 1974

ORDER OF THIS COURT DATED JANUARY 7, 1975 DENYING MOTION

(Filed January 9, 1975)

Moving Papers Filed–December 19, 1974

Answering Papers Filed–January 2, 1975

Date Submitted to Court–January 6, 1975

Date Argued–

Date Decided–January 7, 1975

ORDER

This matter having been duly presented to the court, it is hereby ordered as follows:

Motion to Comply with Order of the Court
Granted– Denied X Other–

SUPPLEMENTAL:

I hereby certify that the foregoing
is a true copy of the original on file
In my office.

Elizabeth McLaughlin, Clerk

FOR THE COURT:

/s/ Robert A. Matthews
ROBERT A. MATTHEWS
P.J.A.D.

Witness, the Honorable Robert A. Matthews, presiding Judge of Part G, Superior Court of New Jersey, Appellate Division, this 7th day of January 1975.

Elizabeth McLaughlin
Clerk of the Appellate Division

HOSPITAL INVOICE FOR BLUE CROSS SUBSCRIBERS SHOWING "DISCOUNT"

	Charges	Credits	Amount
76 days @ $135.00 S.P.	$10,260.00		
1 day @ 69.00 S.P.	69.00		
1 day @ 71.00 S.P.	71.00		
oxygen	84.00		
blood gas studies	798.00		
med. & surg. supplies	160.50		
intravenous solutions	98.75		
drugs & medications	570.75		
laboratory	3,693.50		
blood	100.00		
admin. blood-plasma	30.00		
x-rays	231.25		
bill breakdown	4.00		$16,170.75
Paid by patient		$ 4.00	
Paid by N J Hospital Plan		8,057.40	
Difference absorbed by Hospital		8,009.35	
Blood replacement		100.00	$ .00

FIRST AFFIDAVIT OF FRED WILLIAMS

FRED WILLIAMS, of full age, being duly sworn upon his oath deposes and says:

1. I am employed by Local 464 of the Amalgamated Meat Cutters and Food Store Employees Union and I am fully aware of and involved in all aspects of administering the Welfare Fund of Local 464, including specific hospital charges.

2. Daniel Webster, a member of the Welfare Fund, who was also covered under the New Jersey Hospital Plan's coverage, compiled a total bill at Newark Beth Israel Medical Center of February 25, 1972. Of this total bill only $8,057.40 was paid by the New Jersey Hospital plan, while $8,009.35 was "absorbed by the Hospital" as stated in their invoice of April 25, 1972.

3. This "absorbtion by the Hospital" is the result of the exclusion of certain legitimate expenses from the reimbursement formula applied to Blue Cross subscribers with the result that these expenses must be charged to and shared by the remainder of the patients who are not Blue Cross members. This inequitable system results in Blue Cross being charged less than its fair share of the hospital's costs. All others, including members of the Local 464 Welfare Fund, are charged more than their fair share.

4. This inequitable situation is emphasized by reference to a specific example. Howard Marks, a member of the Welfare Fund of Local 464, while a patient at Bayonne Hospital, was billed at a per diem rate of $65.00 per day for a semi-private room on, or about April, 1971. The per diem rate charged Blue Cross members for the same or similar services at this time was approximately 20% less than the rate charged Mr. Marks as a non-Blue Cross subscriber.

/s/ Fred Williams

NOTARIZED.

SECOND AFFIDAVIT OF FRED WILLIAMS

STATE OF NEW JERSEY)
) SS.
COUNTY OF HUDSON)

FRED WILLIAMS, of full age, being duly sworn upon his oath deposes and says:

1. I am employed by Local 464 of the Amalgamated Meat Cutters and Food Store Employees Union and I am fully aware of and involved in all aspects of administering the Welfare Fund of Local 464, including specific hospital charges.

2. In adidtion thereto, I am aware of the policy concerning charges by hospitals in New Jersey to Blue Cross subscribers, concerning calculation of per diem rates, and the discriminatory practices employed by said hospitals and Blue Cross (New Jersey Hospital Plan) in arriving at these rates by arbitrarily excluding certain cost items.

3. I would like to repeat, reiterate, and make a part hereof the specific instances outlined in my first Affidavit (Affidavit I–see attached) which indicates the discriminatory rate charges that are employed by New Jersey Hospitals to non-Blue Cross subscribers. (See attached bills)

4. The discriminatory rate scheme is an accepted fact today; however, the fact that remains unknown is the method employed by New Jersey hospitals, in conjunction with Blue Cross and with the State of New Jersey, its Commissioners of Insurance and Health as overseers, in arriving at said rate.

5. The secrecy of the negotiations between Blue Cross and New Jersey Hospitals in calculation of their formula which determines the rates to be charged Blue Cross,

which as a result also fixes the high discriminatory rate charged to non-Blue Cross subscribers, has denied the Union Welfare Fund the opportunity of knowing exactly what specific cost items are included or excluded in the calculation of the Blue Cross formula.

6. I know that certain cost items are arbitrarily excluded from the calculation of Blue Cross formula, but it is not known specifically which items are excluded or included and the rational purpose, if any, for such exclusion!

7. What costs from the *total* hospital operating costs are excluded or included? What about other expense items? What losses are incurred, totally and individually per Blue Cross patient as a result of such arbitrary exclusion, thereby necessitating this loss to be passed on to non-Blue Cross patients?

8. These questions of fact must be answered to enable a determination to be made as to the rationality of such arbitrary action. Therefore, discovery must be allowed to enable the legality of such practices to be exposed.

/s/ Fred Williams
FRED WILLIAMS

NOTARIZED.

MEMORANDUM OF LAW SUBMITTED BY PLAINTIFFS IN SUPPORT OF THEIR MOTION TO HAVE THE COMMISSIONERS COMPLY WITH THE PRIOR ORDERS OF THE COURT, INCLUDING AFFIDAVIT

II. Appellants' motion for an order requiring the Commissioner of Insurance to comply with its orders of January 22, 1974 and of July 8, 1974, should be granted

Procedural History

and

Statements of the Facts

In lieu of a duplicitous statement, the appellants incorporate and make a part hereof, a copy of their Attorneys' Affidavit in Support of the Motion.

ARGUMENT

The appellants respectfully submit that the Commissioner of Insurance has not only failed to comply with its twice-issued Order, but that he has failed to address himself to same.

N.J.S.A. 26:2H-17(d) reads as follows:

> Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In *establishing* such rates, the commissioners shall take into consideration the total costs of the health care facility. (L.1971, c.136 § 18, approved May 10, 1971. (emphasis added)

Thus, this Court has twice Ordered that:

"... (2) The matter is remanded to the Commissioner of Insurance for the purpose of expanding the record particularly with respect to the method used and the factors considered by him in *establishing* the rates payable by the Hospital Service Plan of New Jersey (Blue Cross and Blue Shield), as required by *N.J.S.A.* 26:2H-18. When completed the same shall be filed as part of the record on this appeal."

Yet, the Attorney General, in his brief on behalf of the Commissioner, states that the "Expanded Record" . . . "is responsive to the court's remand order in that it provides a comprehensive statement of, *inter alia*, the method used and the factors considered in *approving* reimbursement rates payable by the Hospital Service Plan of New Jersey as required by *N.J.S.A.* 26:2H-18 and *N.J.S.A.* 17:48-7."

The appellants submit that the Expanded Record is *not* responsive to the Court's Order and they, therefore, respectfully submit that if the Commissioner felt that he could not comply with the language of the Order, then he should have objected to the form of the Order so that this matter could proceed in due course.

In *arguendo*, assuming that the expanded record was properly addressed to the Orders, the appellants must urge that such record, as expanded, is incomplete and otherwise defective.

In page 5 of the Attorney General's brief, it is stated that the record ". . . dispels the misconception that the Commissioners do not take into account the *total costs* of hospitals *as required* by *N.J.S.A.* 26:2H-18(d)." (emphasis added)

Thus, we have a tacit admission by the Commissioner that he has an obligation to take into consideration the

total costs of health care facilities. However, on page 19 of the expanded record it is stated that the total expenses of the hospital is used only as a "starting point" for any reimbursement calculation.

It is further stated on the same page:

"This is *reduced* in the Contracting Agreement, by costs which are inappropriate for reimbursement purposes. At Budget Review, the budgeted expenses may be *further reduced* by amounts which, it is felt, a hospital need not spend to provide efficient, high quality health care services—the expectation is that the hospital, so notified in advance, will in fact not incur these unnecessary costs. Finally, the hospital may be *denied reimbursement* of actual expenses following cost review, if those costs have exceeded the Budget Review recommendations. The purpose of this is not to save money for Blue Cross and its subscribers, but rather to limit payments to amounts that were agreed, in advance, should constitute "reasonable" expenses as required by statute." (emphasis added)

Nowhere in the expanded record is there any authority cited for such a procedure.

Nowhere are there any itemization or enumeration of *which* costs are deemed "inappropriate" and therefore excluded.

Nowhere is the regulations and procedure described whereby such costs are determined "in advance" to be "inappropriate."

Nowhere is it stated who makes such determinations, and who has the authority to do so.

Nowhere is there any record that could support the "expectation" that "the hospital so notified in advance, will in fact not incur these unnecessary costs."

Furthermore, we have no idea if such things are determined at meetings; if so, by whom they are attended, and whether or not there are any minutes of same.

Thus it seems quite clear that the" expanded record" is incomplete and defective" and the appellants therefore strongly feel that this appeal is not ready for consideration on the merits.

More particularly, commencing on page 3 of appellants' attorneys' affidavit made in support of their motion and made a part hereof, counsel carefully enumerated and graphically detailed specific objections to the "record" which should render same incomplete and defective. It is respectfully submitted that the brief filed by the office of the Attorney General has not even addressed itself to these specific objections, apparently choosing to ignore same. The appellants most respectfully urge this Court to carefully scrutinize these specific objections, and make its own finding as to their significance.

The appellants feel very strongly that this matter must proceed, but we must first have a foundation, a common base of settled facts, without which there cannot be a final determination on the merits.

The appellants further submit that this record is not only important for this appeal but, it is also necessary for the companion case #A-2210-72, which appeal has been fully briefed by all the parties and, as ordered by the court, will be heard on the same day, one to follow the other.

CONCLUSION

For the reasons stated herein, the Court should grant appellants' two motions.

Respectfully submitted,
KRIEGER & CHODASH
Attorneys for Appellants
/s/ David Feinsilver
DAVID FEINSILVER

STATE OF NEW JERSEY:
SS:
COUNTY OF HUDSON :

HAROLD KRIEGER, being duly sworn acording to law, upon his oath, deposes and says:

1. I am a partner in the law firm of Krieger & Chodash, attorneys for the plaintiff-appellant.

2. An action was instituted on behalf of the plaintiff-appellant in the Superior Court of New Jersey, Chancery Division and among the defendants were the Commissioner of Health and the Commissioner of Insurance. The defendant hospitals and the Hospital Service Plan of New Jersey made a motion for Summary Judgment which Motion was granted.

3. A motion was made requiring the Commisioner of Insurance to complete the record by the taking of depositions, the motion was filed on December 26, 1973, and decided on January 2, 1974. On that date, the Court Ordered the Commissioner to expand the record particularly with respect to the method used and the factors *considered by him* in establishing the rates payable by the Hospital Service Plan of New Jersey (Blue Cross and Blue Shield) as required by N.J.S.A. 26:2H-18 . . ." which statute requires that *all costs* be included in fixing or approving rates.

4. On July 8, 1974, this Court again Ordered that "the Commissioner of Insurance shall comply with our Order of January 24, 1974," on or before September 9, 1974.

5. Pursuant to the latter Order on or about September 6, 1974, the Commissioner of Insurance filed with the Court an "EXPANSION OF THE RECORD ON REMAND."

6. It is the position of the plaintiffs that the aforementioned "EXPANSION OF THE RECORD ON REMAND" is deficient in the following respects:

1. The material furnished did not indicate how the final limitation on the amount of per diem payable (as described on page 8) was established. It therein appears that on a tentative rate basis the maximum rate would be the average rates of the highest 10% of the participating hospitals. For those in the upper half of the 10%, this process would mean that they are not being paid the cost of providing services. We therefore request a further explanation of this process.

2. As stated on page 18a, Item G(e) of the material provided

> "It is not contemplated that the Plan will be responsible for costs of capital debt that are excessive either as to the size of the debt incurred compared to the equity support given by sponsors of the facility or as to the rate of interest paid thereon. To implement this objective the amount of interest on capital debt included in reimbursable costs for any year should not exceed an amount arrived at by applying a percentage to the original cost value of the entire plant assets of the hospital. This percentage is to be determined by adding 1½% to the "prime" rate of interest existing at the time the indebtedness was incurred and multiplying this amount by 50%."

It appears that the implementation of this provision can have significant financial repercussions to an individual hospital, resulting in costs not being covered by the Blue Cross reimbursement formula. We therefore request a further explanation of this provision.

3. It appears from the "EXPANSION OF THE RECORD ON REMAND," that there is an unjustified limitation on the amount of expense absorbed by Blue Cross, relating to computer operations. As a consequence thereof, individual hospitals may very well have administrative costs that are wrongfully not being paid by Blue Cross. We therefore request a further explanation for the formula as used.

4. Perhaps the area where in the factual and legal bases are most occluded is that dealing with bad debts. This is a very substantial item, particularly in hospitals such as those located in center-cities, where a significant proportion of the patients do not pay. Such items must be broken down into three parts:

a) *Emergency out-patient treatment.* As indicated in the paragraph in the middle of page 17, a hospital may include the emergency room indigent loss in total reimbursable expenses, which results in Schedule V-B in Blue Cross paying "its share" based on its proportion of in-patient days But some in-patients do not pay. Therefore, no share of the emergency out-patient losses is borne by this non-paying in-patients. The net result, of course, is that the hospital either loses money or charges the paying non-Blue Cross in-patients more than their proportionate share of the emergency out-patient losses.

b) *Non-emergency out-patient losses.* This is described in the paragraph that runs from the bottom of page 17 to the top of page 18. We question the validity of the assumption that charges for such services are set at a level sufficient to cover indigent losses and bad debts arising from out-patients. If we read this paragraph correctly, Blue Cross does not pay its proportionate share of the non-emergency out-patient losses.

c) *In-patient indigent losses and bad debts.* It appears quite clear that Blue Cross does not pay its proportionate share of this item. Line X of Schedule 1 and Schedule 111 C indicate that they reimburse only for the bad debts resulting from New Jersey Blue Cross in-patients.

Inasmuch as bad debts present serious budgetary problems for almost all hospitals, we must herefore request that the Commissioner's consideration of same, pursuant to *N.J.S.A.* 26:2H-18, be described in further detail, especially since the broad question of what is Blue Cross's proper proportionate share (of bad debt expenses and/or losses), appears either to have been answered by assumption or conjecture, or perhaps even ignored.

By way of example, we offer the following:

1. On page 17, it is stated that there are indications that the additional revenues from Blue Cross subscribers who "choose" to occupy a private room may exceed in-patient indigent losses for most New Jersey hospitals. The validity of this statement may be questioned. What about the private-room patient who did not choose it?

Our information, obtained through direct calls to a number of hospitals, indicates that the proportion of private beds to total beds is so small that their use by Blue Cross patients could not make a contribution to hospital revenue equal to the cost of indigent care.

The following information was gained:

	Total Beds	Private Beds
St. Barnabas	668	25
Monmouth Medical Center	450	22
Hackensack Hospital	450	46
Muhlenberg Hospital	430	20

2. Also, as mentioned above, there is the question of who pays for the out-patient losses, particularly the non-emergency.

A simple hypothetical numerical example will illustrate this. Suppose that a hospital's total in-patient days are distributed as follows:

Medicare	25%
Medicaid	20%
Blue Cross	30%
Other Paying Patients	15%
Non-Paying Patients	10%

As we read the instructions, Medicare, and possibly Medicaid, patient days are subtracted from the total, leaving 55% of the total patient days. If Blue Cross pays "its proportionate share," it will pay 30/55ths. Therefore, the hospital must either charge the other paying patients 25/55ths of the bad debts, which is far more than their proportionate share, or will be unreimbursed for 10/55ths if they only charge the other paying patients their proportionate share.

5. It is noted that both the public defender, Mr. Martin L. Haines, Esq., and the Actuary of the Insurance Department, Mr. William White, stated in the record that charges to non-Blue Cross non-governmental patients customarily exceed Blue Cross reimbursement rates by about 20%. It is evident that these higher charges do not produce fat profits for the hospitals. On the contrary, they are direct and necessary consequence of the Blue Cross reimbursement formula. In light of the foregoing, we feel compelled to request that as part of the "record," that the Commissioner, pursuant to *N.J.S.A.* 26:2H-18, take a position as to whether or not *all costs* have been included in fixing or improving the rates.

6. For the purpose of establishing a clear "record," we further request that the Commissioner, pursuant to *N.J.S.A.* 26:2H-18, advise us as to whether or not such items as the training of personnel, research and depreciation, as well as other "hidden costs" incurred by such hospitals are included as part of the total cost for the fixing of rates to be paid by Blue Cross.

7. We find it necessary to object to the form of the "EXPANSION OF THE RECORD ON REMAND," inasmuch as we feel that the aforementioned "record" does not comply with the directives of this Court in that said "record" does not contain findings of fact or determinations of law as made by the Commissioner.

8. For purposes of this motion, I, as attorney for the plaintiffs, further incorporate by reference my prior Affidavit in support of the previous motion to comply with the Order of the Court.

Respectfully submitted,

KRIEGER & CHODASH

By: /s/ Harold Krieger
HAROLD KRIEGER

NOTARIZED

APPELLATE DECISION IN BORLAND, et al. v. BAYONNE HOSPITAL, et al

Argued June 3, 1975—Decided July 3, 1975

Before Judges Matthews, Fritz and Botter.

On appeal from the Superior Court, Chancery Divsion, Hudson County.

Mr. Harold Krieger argued the cause for appellants (Messrs. Krieger & Chodash, attorneys; Mr. Frank L. Brunetti, on the brief).

Mr. Bruce D. Shoulson argued the cause on behalf of all respondent hospitals (Messrs. Lowenstein, Sandler, Brochin, Kohl & Fisher, attorneys for respondent Beth Israel Medical Center; Mr. Michael L. Rodburg, on the brief).

Mr. Omer F. Brown, II, Deputy Attorney General, argued the cause for respondent Commissioners of Insurance and Health (Mr. William F. Hyland, Attorney General, attorney; Mr. Stephen Skillman, Assistant Attorney General, of counsel).

PER CURIAM

We affirm substantially for the reasons expressed by Judge Fink in his opinion reported at 122 *N.J. Super.* 387 (Ch. Div. 1973).

APPELLATE DECISION IN BORLAND, et al v. RICHARD McDONOUGH, et al

Argued June 3, 1975—Decided July 3, 1975

Before Judges Matthews, Fritz and Botter.

On appeal from the Commissioners of Insurance and Health.

Mr. Harold Krieger argued the cause for appellants (Messrs. Krieger & Chodash, attorneys; Mr. David Feinsilver, on the brief).

Mr. Omer F. Brown, II, Deputy Attorney General, argued the cause for respondents (Mr. William F. Hyland, Attorney General, attorney; Mr. Stephen Skillman, Assistant Attorney General, of counsel).

PER CURIAM

This case is a companion to *Borland, et al. v. Bayonne Hospital, et al.*, 122 *N.J. Super.* 387 (Ch. Div. 1973), which we affirmed this date.

After the Chancery Division Judge granted summary judgment in favor of defendant hospitals in the companion case, the action remained pending against defendant commissioners. The commissioners then moved before the Chancery Division to transfer that action to this court since it then consisted of an appeal from an administrative decision of a State agency. See *R.* 2:2-3(a)(2). The motion was granted. Thereafter, we remanded the pending action to the commissioners for expansion of the record. The record, as expanded, has been returned and we proceed to a disposition of the merits.

Basically, plaintiffs complain that the differential in the rates paid by the Hospital Service Plan of New Jersey

(Blue Cross) to hospitals as per diem reimbursement are discriminatory against them because that rate is lower than the rate charged by the hospitals to non-Blue Cross subscribers. The same constitutional arguments advanced in *Borland, et al. v. Bayonne Hospital, et al.*, above, are advanced here. The arguments of discrimination involving the equal protection clause were rejected in the companion case by the Chancery Division Judge, and we affirmed that rejection. We see no reason to change our decision because of the arguments advanced here. [We are satisfied that there is a *failure* on the part of plaintiffs *to prove* that the *differential in rates* charged by the hospitals because of the action of the commissioners *constitutes* either a *deprivation of due process or equal protection.*]

Plaintiffs also contend that the statute relevant to the duties of the commissioners in approving reimbursement rates mandates that the hospitals be reimbursed so that they recoup their total costs. The statute in quesion, *N.J.S.A.* 26:2H-18, reads in perinent part:

> b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him. • • •
>
> d. • • • In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

We do not read the statute as requiring that the rates fixed reimburse the hospitals so that they recoup their total cost outlay; rather, the statute clearly requires only that the commissioners consider the total costs in determining the percentage of costs to be reimbursed. To hold otherwise would divest the commissioners completely of discretion and actually render unnecessary the approval proceedings

required by the Legislature under the statute, thus reducing the commissioners' duties to nothing more than a rubber stamp.

Plaintiffs next argue that the guidelines under which the commissioners are to determine the approved reimbursement rates are unduly vague. As noted, the statutes require that the commissioners approve reimbursement rates after considering the hospitals' total costs. The legislative scheme established obviously relies upon the commissioners' expertise and the proper use of discretion in a very complex area. Delineation of specific statutory guidelines would serve only to restrict the commissioners' exercise of discretion. The exercise of discretion by the commissioners, and the establishment of guidelines by them in carrying out the legislative mandate are subject to judicial review. See *N.J.S.A.* 26:2H-17.

Finally, plaintiffs argue the commissioners must hold hearings before setting reimbursement rates. We have so held recently in an unrelated case. *Monmouth Medical Center, et al. v. State of New Jersey, et al.*, Docket numbers A-2147-74 to A-2151-74, incl.

Affirmed.

A TRUE COPY

/s/ Elizabeth McLaughlin

REPORT OF HEARER; IN THE MATTER OF THE 1975 HOSPITAL RATE REVIEW PROGRAM GUIDE LINES PROMULGATED BY THE COMMISSIONERS OF HEALTH AND INSURANCE IN FEBRUARY, 1975

On June 11, 1975 a hearing was held before me as hearer duly appointed to take testimony and receive statements and exhibit with repect to the 1975 Hospital Rate Review Program Guidelines promulgated in February 1975 by the Commissioners of Health and Insurance.

The Appellate Division of the Superior Court had, in *Monmouth Medical Center v. State of New Jersey*, determined that the Guidelines were promulgated in violation of the Administrative Procedure Act (*N.J.S.A.* 52:14B-1 *et seq.*). It accordingly remanded the matter to the Commissioners to proceed forthwith to fix reimbursement rates under the Health Care Facilities Planning Act (*N.J.S.A.* 26:2H-1 *et seq.*), in accordance with law, the proceedings to be concluded on or before June 1, 1975. The court not only invalidated the Guidelines but also any action taken thereunder by the Commissioners, including but not limited to the establishment of the 1975 initial *per diem* reimbursement rates. It declined to fix the rates at which hospitals were to be reimbursed by hospital service corporations.

Thereafter the Commissioners, on May 5, 1975, jointly promulgated the same 1975 Guidelines, to be used for a period of 60 days for the purpose of fixing interim rates. They also gave notice of a hearing to be held on June 11, 1975 for the adoption of the Guidelines as a temporary rule. To justify their adoption of the Guidelines without a hearing, the Commissioners filed certificates of emergency, purportedly pursuant to the authority of *N.J.S.A.* 52:14B-4(c).

The *Monmouth Medical Center* plaintiffs thereupon filed a petition for a rehearing of their earlier applications for relief, alleging that the Commissioners had not complied in good faith with the court's earlier determination. The Appellate Division again invalidated the adoption of the Guidelines and directed that a hearing must be held, on short notice, to give interested parties an opportunity to be heard. It extended for a reasonable time the period previously fixed for establishing interim reimbursement rates.

An estimated 300 persons attended the hearing on June 11, 1975. Over 60 requested an opportunity to be heard. Many of them did not respond when their names were called, but some 36 made oral presentations. Anyone present was given a week to file a statement of views and such other materials as were relevant to the matter under consideration. Many such statements and a considerable volume of materials were thereafter submitted. What follows reflects a study of the voluminous record, which includes not only the transcript of the hearing testimony, but statements filed, supplemental exhibits in support of the views given by those who support or oppose the Guidelines, and the Appellate Division briefs filed in the *Monmouth Medical Center* case, *Beth Israel Hospital vs. Finley*, and *Borland vs. Bayonne Hospital*.

The background facts and developments leading to the promulgation of the Guidelines were provided in the presentation of the Commissioner of Insurance and that made by Miss Cathleen A. Maloney, Chief, Health Facilities Analysis, in the Department of Health. As explained in the presentation made on behalf of the Commissioner of Insurance by Dr. Eleanor J. Lewis, the Department's Director of Consumer Services, the year 1974 represented a transitional period for the State's responsibility in fixing reimbursement rates under the Health

Care Facilities Planning Act. It was represented that prior to that year the hospital rate-setting process could well be described as a "peer review" program administered by the hospital industry itself. Hospitals entered 1974 with the assumption that that program would be maintained. Budget forms had been sent to all New Jersey hospitals during the third quarter of 1973 with instructions that they be completed and returned to the Hospital Research and Educational Trust (HRET—essentially the New Jersey Hospital Association) by December 1973. The forms were analyzed by the HRET staff and subsequently reviewed by members of the Budget Review Committee, consisting of some 30 New Jersey citizens, half of them hospital administrators, a quarter hospital trustees and a quarter hospital physicians.

The Insurance Commissioner reviewed the first set of Budget Review recommendations in late January 1974, and those involving some 28 hospitals were routinely approved consistent with prior practice. The Insurance Commissioner went on to explain that late in February 1974 it had become apparent that the recommendations of the Budget Review Committee were resulting in increased expenditures of about 12% by Blue Cross and Medicaid, as compared with payment rates for 1973. The Economic Stabilization Program was then still in effect, with a stated objective of limiting annual hospital cost increases to 6%. The then Acting Commissioner of Health and the Insurance Commissioner accordingly withdrew approval of the Budget Review-recommended rates as of March 1, 1974, and instituted studies of alternate methods for rate-setting which would entail a considerably greater degree of State involvement.

The first step in that process was effected on May 1, 1974 when, in an explanatory letter to the hospitals, the

basic objectives underlying the change in method were defined. These were that (1) the system must produce reasonable payment rates, within the letter and spirit of the statute, within which hospitals might be expected to be able to operate without adversely affecting a high quality of patient care; (2) the system had to have sufficient flexibility and responsiveness to recognize and accommodate changing economic factors and exceptional conditions, in order to avoid undue financial hardship for any hospital or the hospital industry as a whole; (3) the system should preserve the concept of peer review and the product of the Budget Review process, to the extent that these were not in conflict with the State's obligation to control the over-all level of hospital costs; and finally, (4) the system should put both the hospitals and Blue Cross on notice as to the consequences, in connection with final payment rates, of significant departures from tentative payment rates that had been established.

In his statement the Insurance Commissioner explained that this system produced payment rates which, on the average, were about half a percent less than had been recommended under the traditional Budget Review process. Since the release of these rates coincided with the termination of the Economic Stabilization Program, the hospitals were notified that one or two steps would subsequently be necessary to reflect inflationary and other factors as they emerged during the balance of 1974.

The first of these steps was taken in September. It entailed three modifications: (1) a substitution of each hospital's actual 1973 costs for its projected costs in determining an allowable "base year" component; (2) a singling out of energy cost components so as to permit a pass-through of increased costs resulting from the energy crisis, at rates that were realistic, and (3) the introduction of an over-all 9% economic projection factor to replace the

7½% factor underlying the approach of the Economic Stabilization Program. The net effect, said the Insurance Commissioner, was to increase hospital payment rates by about 1.1% over the May 1974 formula rates.

The final step in the program, we are told, was completed in early April 1975. Preliminary work was begun in October 1974, jointly by the Departments of Insurance and Health and representatives of the New Jersey Hospital Association. The first step taken was a questionnaire to each hospital, mailed November 6, 1974, requesting information as to its emerging 1974 costs, patient days and salary increases not anticipated when the original budget was submitted. Based on the completed questionnaire, the original Budget Review Committee's recommendations were recast to reflect the recommendations it would have made had the Committee been aware of the hospital's actual (as opposed to anticipated) patient days and of the salary consequences flowing from the termination of the Economic Stabilization Program. The rates produced by this process, it is said, averaged 2.4% more than the original HRET Budget Review Committee's recommendations for 1974, and 14.9% higher than the corresponding 1973 Budget Review-based rates. The Insurance Commissioner represents that the average 1973 Budget Review-approved rate (the reasonable average cost for one hospital day of inpatient service in New Jersey) was $95.16; the 1974 HRET-recommended reasonable cost came to $106.80, and the corresponding rates, according to the Insurance Department formula, at which hospitals were paid for 1974 admissions was $109.34.

The Insurance Commissioner stated that it had been hoped to release the final payment rates during late December 1974, but this was delayed because certain unavoidable conflicts arose between the Insurance Department

rates and the 1975 rates being developed by the Health Commissioner. Since 1974 was regarded as a transitional year, the rating process had to be compatible with both the prior and subsequent processes. It was therefore not until the first week in April 1975, after substantially all of the initial 1975 payment rates had been determined and the various appeal processes developed by the Health Department, that a complete agreement could be reached on release of the final 1974 tentative payment rates.

Miss Maloney was employed by the Department of Health shortly after the adoption of the Health Care Facilities Planning Act in 1971, to assist in the development of a uniform reporting and accounting system and in the implementation of the rate-setting sections of the law, *N.J.S.A.* 26:2H-5(b) and 18. She stated that until 1974 there were no material regulations approved to implement a State regulatory system for either reporting or rate setting. Finally, in the spring of that year the Health Department decided to obtain the help of consultants. After open bidding, and with the advice of a committee the Commissioners had set up to help in deciding upon the bidder best able to accomplish the task, the consultant contract was awarded the firm of Haskins and Sells. Miss Maloney was designated Project Director.

One of the first suggestions made by that firm was that an advisory committee be established, made up of representatives of those concerned with health care: hospitals, the New Jersey Hospital Association (NJHA), physicians' organizations, Blue Cross, hospital labor unions, private insurance companies, the State Medicaid Program and the Departments of Health and Insurance. The Departments proceeded to set up an Advisory Task Force Committee and to hold meetings of interested parties in order to obtain industry advice and input in connection

with the proposed 1975 rate-setting system. Agenda were prepared for Committee meetings and memoranda mailed to its members following their sessions. I have examined the composition of the Advisory Task Force Committee, its agendas, and the meeting memoranda; this record attests to the representative character of the Committee and the breadth and depth of its discussions and determinations.

On September 17, 1974 the Commissioners of Health and Insurance sent a joint memorandum to the chief executive officers of all New Jersey hospitals "to let concerned hospital officials know as soon as possible, the plans of the responsible Departments of the State for hospital budget review and rate setting for 1975." The memorandum stated that the Departments would undertake determination and certification of rates for 1975 in accordance with the mandate contained in the Health Care Facilities Plannng Act, and to facilitate the transition to the new system the Departments would use data prepared by the chief executive officers on the 1975 HRET forms already mailed to them. These forms were to be filed with the Department of Health by November 30, 1974. Another joint memorandum was mailed on October 9, along with supplemental forms and instructions needed for a proper analysis of the 1975 budget submissions. The hospitals were informed that the Departments would expect to begin issuing initial rates for 1975 during February 1975.

The Advisory Task Force Committee early set up subcommittees to make specific studies of concepts and elements to be used in the new rate-setting system. These subcommittees were: Reasonableness Guidelines, Inflation, Classification Structures, and Incentives. I have examined the record of the work of these subcommittees as contained in the reports issued after their meetings and

find there was significant input from the various sectors of the health care industry.

The Departments also issued an "H & I Newsletter" so that all hospitals would be aware of the progress the Departments were making in setting up the 1975 system. The first was issued September 17, 1974 and was followed by six other "Newsletters" giving detailed information of developments.

The first draft of the Reasonableness Guidelines was reviewed at a joint meeting on January 27, 1975 of the Advisory Task Force and the subcommittee on Reasonableness. A copy of that draft had been sent to all members on January 10, accompanied by a comment sheet requesting written comments on the draft. The Department of Health received only four comments, and it would appear that the January 27 meeting elicited no strong exceptions to the proposals. The draft and comments have been made available to me. The draft did not include a quantification of the Guidelines, that section not yet having been made final.

The next step taken was in early February 1975 when the Commissioners notified the hospitals that there would be foura rea workshops at which the Guidelines would be explained to hospital representatives. The workshops appear to have been well attended, and efforts were made to clarify issues that were of concern to the hospitals.

As Miss Maloney explained, and as certain correspondence before me indicates, members of the Advisory Task Force Committee and subcommittees specifically asked the Commissioners to state that although they had participated in committee work and provided a certain input for the Committee's findings, it should be understood that they were not in total agreement with all items in the

Guidelines nor with the system as finally developed by staff. However, Miss Maloney stated that, as Project Director, she felt there were some items which, in her words, "had sufficient confirmation from the hospital industry." Quoting from her hearing presentation, these items were as follows—and in quoting them I must note that there were those at the hearing who took objection to some of them:

The General Approach:

Rate setting involves answering the questions as to the reasonableness of the proposed cost increases. This approach was taken to respond to the criticism of other states' regulatory bodies that established a base year without any analysis as to which hospitals were well run and low cost during the base year and which hospitals were inefficient and high cost. To set rates without establishing base year efficiency penalizes the well-run hospital while the inefficient thrives because of the surplus built-in from the use of a base with no cost constraints.

Cost Centers:

The Departments combined all reported cost centers into thirty-one different centers to achieve some uniformity as to the components of each cost center. HRET previously had neither defined the components nor classified costs to ensure uniformity in reporting.

The members agreed to these costs centers and to the three levels at which costs could be analyzed:

Level I--cost centers that are common to all hospitals.

Level II—costs incurred by physician coverage, physician salary fees, interns and residents.

Level III—costs that are either non-controllable by the hospital, immaterial as regards rate determination, or costs for which accepted common bases are not available for comparison.

Budget Groups:

The concept of Budget Groups was discussed with the Advisory Committee and the Reasonableness Guidelines Committee. There was general agreement that the grouping of budget expenses made good sense from an operational standpoint. The Budget Groups established by the State's system aligned themselves to those used by HRET-Budget Review.

Modified Per Diem	Group A
Physician Coverage and Education	Group B
Depreciation and Interest	Group C

Hospital Peer Groups:

When the State took over the regulatory system they could not retain "peer review." Therefore the system set up peer groups in order to give the hospitals the opportunity of being compared to hospitals they considered to be similar. Significant input was given by the Advisory Task Force to determine the criteria for peer groupings and the Departments responded to every proposed change. Hospitals who expressed difficulty with the group they were assigned to for peer comparisons were changed into the group that they felt were cost comparable in operations, complexity of services, size and location.

Inflation:

There was total agreement on this section as the actual rate of inflation will be adjusted at the end of the year. Hospitals and New Jersey Hospital Association members

worked closely with the Departments in designing the "market basket" concept for measurement of actual inflation during 1975.

Volume Variances:

Volume variances are a necessary part of the system since hospitals historically have not projected their patient day load with any great accuracy. Since payment rates are based upon patient days a poor projection of utilization results in a higher *per diem* at year's end when no variance to total budget dollars is built into the system in response to patient day decline.

All members agreed that there was no real way that the Committee could come to total agreement on volume variances, but they did agree with the concept that some expenses are fully variable, some fully fixed, and other semi-variable. Each member had a suggestion as to the percent of variability for volume but it was admitted that suggestions were more than likely subjective as they are influenced by the way member hospitals actually responded to problems of utilization. The majority of the members did agree with the variability factors as set down in the Guidelines as being as reasonable as any other that might be suggested. No one felt he could justify the use of other variability factors as being any more reasonable or valid.

Appeals:

Much of the time of the Advisory Task Force was spent on the discussion of the appeals mechanism. New Jersey Hospital Association did say that they did not like the proposed appeal mechanism, particularly the proposed public or impartial compositions of the Commissioners' Appeals Board.

The appeals process, as drafted by the Committee, was published in the February 6, 1975 issue of the *New Jersey Register*. Before adopting the appeals rules, the Commissioners incorporated suggestions submitted by NJHA as to the composition of the Commissioners' Appeal Board. An appeal mechanism has thus been part of the Guidelines from the start.

The Advisory Task Force Committee did not help formulate nor did it agree to the section of the Guidelines dealing with quantification. The Committee members were of the opinion that definition of the line above which costs were to be questioned was for determination by the Commissioners. The Committee viewed its role as purely advisory and left to the Commissioners the task of setting reasonable payment rates.

In her statement at the hearing, Miss Maloney said that when initial rates for 100 hospitals were issued in February 1975 they were, on the average, 8% above the operating budgets recommended for 1974 by the HRET-Budget Review, and 7% over the July payment rate issued by the Commissioner of Insurance that hospitals were receiving at that time. These initial rates were issued on the advice of the Advisory Task Force Committee members who felt it would help the hospitals' cash flow and at the same time give the Departments ample time to review hospital budgets in detail and revise the rates. Issuance of the 100 initial rates made available average *per diem* increases some three months before HRET would have completed its budget hearings for the hospitals in question.

The statement presented by Dr. Lewis at the hearing on behalf of the Insurance Commissioner, and the statement (with its extensive exhibits) presented by Miss Maloney of the Health Department provided the hearer with

the necessary backdrop leading from the passage of the Health Care Facilities Planning Act of 1971 to the promulgation of the Guidelines. Before proceeding to a discussion of those parts of the record addressed to the Guidelines proper, reference should be made to sections of the Act pertinent to the subject matter under consideration.

Section 1 of the Act (*N.J.S.A.* 26:2H-1) declared it to be the public policy of the State that

> • • • hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health.

The Department of Health is given "the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services."

Section 4 (*N.J.S.A.* 26:2H-4) establishes in the Department of Health a Health Care Administration Board consisting of 13 members, 11 to be appointed by the Governor with the advice and consent of the Senate, and representative of medical and health care facilities and services, labor, industry and the public at large, and 2—the Commissioners of Health and Insurance or their designated representatives—to be members *ex officio*.

Section 5(b)—*N.J.S.A.* 26:2H-5(b)—provides

> b. The Commissioner, with the approval of the board, sall adopt and amend rules and regulations in accordance with the Administrative Procedure Act P.L.1968,c.410(C.52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements

for a uniform State-wide system of reports and audit relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18; and (3) standards and procedures relating to the licensing of health care facilities and the institution of additional health care services.

Finally, Section 18(c) and (d)—*N.J.S.A.* 26:2H-18(c) and (d)—states that

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

The purpose of the scheduled hearing was to inquire as to whether the Guidelines meet the test of reasonableness. The hearing was not concerned with the constitutionality of the Health Care Facilities Planning Act or with the actual rates thus far fixed.

A number of those who appeared at the hearing spoke of the particular healt hcare facilities they represented—their uniqueness in light of location, the character of the area served, the services rendered, patient mix, the existence of special programs and their extent, intensity of service, complexity of cases handled, and the like. Either explicit or implicit in some of these comments was that the best system would be the one that formerly existed, namely, to consider budgets and fix rates on a hospital-by-hospital basis. [In my view this misses the entire *purpose of the Health Care Facilities Planning Act*, which is *to establish reasonable rates* in light of overall consideration and analysis of health care costs, derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health].

And here I find unacceptable the characterization attributed to the Guidelines as being conceptual or formulistic. The approach to any problem must begin with one or more concepts which are discussed, analyzed and sorted out as practical and relevant in light of the factual complex which the problem involves. This is precisely what took place in the development of the Guidelines, as shown by the background history traced by Dr. Lewis, speaking for the Commissioner of Insurance, and by Miss Maloney of the Department of Health. After the Act was adopted in 1971 there was what has been described as "peer review" in the rate-setting process. Then came a short period of HRET-Budget Review input. There followed the first steps in the development of what are now the Guidelines—the joint product of the Departments, their consultants and the Advisory Task Force Committee and its subcommittees. The hospital industry was accorded every opportunity for presenting its ideas and constructive criticisms. In the end there emerged the Guidelines under discussion.

I find no merit in the claim that the Guidelines are formulistic, if what is meant by that term is that they lay down a hard and fast pattern to be applied in an absolute fashion to the hospital industry of New Jersey. The facts belie the characterization, for it ignores the process that is available to every health care facility. The Guidelines and the rules concerning 1975 rate review give every hospital the opportunity of sitting down with a staff analyst to discuss and possibly adjust the initial rate set. If this is not satisfactory, there is available an administrative appeal, open to the public. And if the result achieved still remains unsatisfactory, the hospital may appeal matters of policy and unresolved matters to the Commissioners' Appeals Board. The same appeal procedure is available as to the final rate. (Here it is appropriate to correct the remark of one speaker, that the Appeals Board has not yet been established; the contrary is true and the Board is functioning.) In short, the Guidelines and rules provide a flexibility that assures health care facilities a thorough review and adjustment of initial and final rates.

There is no need to review the Guidelines in detail, for they have been available for some time and are familiar to all interested parties. As stated in the Introduction to the Guidelines, the development of reasonableness guidelines for the 1975 hospital rate review program has been guided by the following constraints:

> The use of the HRET forms, data elements and definitions supplemented by selected actual data for 1974;
>
> The terms of existing Blue Cross contracts with the hospitals;
>
> The need to establish promptly an initial inpatient per diem rate to be used by Blue Cross, Medicaid and Title V for hospital reimbursement during 1975, and
>
> The requirement to determine final 1975 inpatient per diem rates based upon actual 1975 data.

As the Introduction expressly notes, the Guidelines represent *general* instructions to guide the Health Department analysts in their review of hospital budget submissions and their determination of payment rates. The instructions are explicit and detailed to insure that all hospitals are uniformly and objectively reviewed.

The approach to determining the reasonableness of operating costs involves a multi-faceted analysis of the functions of a particular hospital within a group or groups of hospitals. This analysis comprises three essential elements which may, in summary, be described as (1) data definiton by cost centers, peer groups and units of service; (2) a method for measuring reasonableness by base period costs, cost increases and employee compensation levels, and finally, (3) the quantification of the Guidelines.

Each of these three essential elements is carefully explained in detail in the Guidelines so that not only the Department analysts but the health care facilities may clearly understand what is involved in the rate-setting process. As Kathrine G. Bauer, Research Associate at the Harvard Center for Community Health and Medical Care, who has for the past few years been studying the processes of hospital rate-setting in seven programs in various parts of the nation, stated, one must remember that there is no established wisdom in the area of hospital rate-setting. This is an extremely complex and delicate task. It is complex because the product to be priced is so difficult to define and its quality so difficult to measure,

and any comparison rate reviewers try to make must take into proper account the current diversity among hospitals. There is also the fact that each hospital organizes and manages its particular activites in its own way, including the keeping of its accounts. And, Dr. Bauer continued, rate-setting is a delicate task because there are almost no recognized performance standards for hospital care, so that rate reviewers are forced to make either implicit or explict value judgments in reaching decisions. Finally, said Dr. Bauer, we presently lack definitive experience, since almost all rate review programs in the country have been operating for less than five years. She made these points in order to urge that whatever program New Jersey adopts for 1975 must necessarily be approached in an experimental way, with mechanisms built in for on-going evaluation and improvement.

Dr. Bauer was of the opinion that the Guidelines program for rate-setting operates within the general framework of the Act and so has a great potential for reinforcing the planning powers of the Health Department. She to establish a fair review process in that a distinction has been made between controllable and uncontrollable types of hospital costs. And there is a distinction between fixed and variable costs, with an allowance for volume changes, although in this area the particular parameters selected might be refined. The peer groupings of hospitals for comparison purposes are considerably less crude than those employed by many other programs, including Medicare, although such grouping also requires refining. In her opinion the appeals process, described as a crucial element in any rate-setting program, seemed designed to resolve differences in a timely manner.

Dr. Bauer pointed out that the specific criticism she had of the program is that hospital reports submitted

cannot be expected to provide truly comparable data: lacking a uniform chart of accounts and uniform reporting conventions, a standard report form can only yield the illusion of uniform data. Here I should observe that in an attempt to arrive at inital rates for 1975, the Department of Health, with the approval of the hospitals, had to use the HRET forms, and this for the purpose of providing the hospitals with initial rates at as early as a date as possible, in aid of cash flow. In light of the 1975 experience and the observations made by those who appeared at the hearing, it is to be expected that the Department will undoubtedly refine the forms used by hospitals in reporting. As noted, 1974-1975 is patently a transitional period.

Lawrence Lewin, President of Lewin & Associates, Inc., of Washington, D.C., a management consulting firm in the health field, had reviewed seven rate review programs and was of the opinion that the Guidelines represented a reasoned approach to rate-setting. He spoke of the use of the median—a line separating 50% of hospitals above and 50% of hospitals below the cost line—as probably too tight. However, as he explained in a letter following the hearing, there exists an appeal process, which must be viewed as an integral part of the rate-setting process, and this effectively neutralizes use of the median as an absolute standard. The problems of the median, criticized by a number of speakers, was in his view an administrative issue determining the number and intensity of appeals, but not necessarily the final approved rate. In his opinion it would probably be administratively wiser to set the median at a higher level, at least during the first year, and he urged that a more liberal criterion be selected in the future. I am in agreement with that opinion, if only because it may decrease the number of Department challenges for hospitals above the median, with resultant

appeals that require considerable time before a revised rate is determined.

Charles Calligaris, a representative of the Health Studies Faculty of the Maxwell School in Public Administration at Syracuse University and experienced in hospital administration, particularly in the area of reimbursement, was impressed by the effort apparently expended in developing the Guidelines. He stated that the program of budget review is consistent with the recent position taken by the American College of Hospital Administrators and with proposals under consideration by the Hospital Association of New York State. The strength of the Guidelines, he said, was in the assurance that all hospitals were uniformly and objectively reviewed. He reviewed various aspects of the Guidelines and found them generally satisfactory. He especially noted the availability of the appeals mechanism as a corrective device. However, although he recognized the benefit of Equivalent Inpatient Days (EIPD) as an analytical tool, he seriously questioned the equalization of units of service for inpatient and outpatient care based on dollar-for-dollar value and believed that this would become a matter of contention. (A number of hearing presentations also criticized the EIPD factor). I would recommend that the EIPD factor be re-studied by the Department in the light of the hearing and hospital appeals. Mr. Callagaris was also critical of setting off increased productivity against increased intensity of service. In a memorandum received from the Department after the hearing the validity of this criticism was recognized, and it is anticipated that a necessary correction will be made.

I have also received a statement from Steven M. Weiner, Chairman of the Massachusetts Rate Setting Commission, a body responsible for establishing rates of payments to

providers under the Massachusetts Medicare Program, and which approves all contracts by hospitals and Blue Cross, including the initial and final rates of payment. He states that the Commission considers the Guidelines an extremely thoughtful approach to the complex and difficult problem of utilizing hospital cost control. In its view the method properly balances the need of assuring public accountability for the use of funds generated from the public, and the issues of hospital financial viability and guarantee of access to hospital care. The Guidelines encompass the major control issues which must be included in any system for effective hospital cost control. The Massachusetts Commission believes that the Guidelines present an excellent base from which, as a result of experience, further refinements will flow. It views the use of the median as a challenge point for unit cost of service as reasonable for the first year. The approach taken with regard to volume variances was appropriate: the classification of 0%, 50% and 100% variables seemed reasonable, and experience would allow further refinement. Mr. Weiner said that the use of EIPDs seems to be required for certain services for which there are no existing measures, and their use appears reasonable.

Edward Karnasewicz, Deputy Director of the Connecticut Commission on Hospital and Health Care, presented a statement for the record in which he said that the approach taken by New Jersey is, in general, similar to that adopted in Connecticut. He fully supported the principles for data definition, the methodology for measuring reasonableness and the quantification pattern set out in the Guidelines. The peer groupings, he said, are an excellent concept; since there are basic similarities between certain kinds of hospitals, it is entirely appropriate to group them. The analysis of base period costs is a good approach. As for EIPD, it would be preferable to

use paid hours as a basis, for it is easier to understand. The use of volume variances is important, and the 0%, 50% and 100% is a reasonable place to start and presumably will be adjusted as experience is gained. The use of 12% as an inflation factor for supplies was generous.

Repeatedly stated in the hearing presentations was that the time lag involved in setting the initial rates and then revised initial rates (after staff adjustments and/or appeals) resulted in financial problems for the hospitals. The initial rates were made available by March 1975, earlier than under HRET-Budget Review system. As of June 16, 52 hospitals had been through the first steps of the appeals process: 30 had administrative appeals hearings and 22 accepted their rates after an office conference. The Department had to reschedule 26 appeals at the hospitals' request. Revised rates were issued in 33 cases. An appeal to the Commissioners' Appeals Board was filed by 2 hospitals. It is expected that all rate adjustments will have been made by August.

The time lag is undoubtedly due to the novelty of the system. The proposed timetable for 1976 is that budgets will be reviewed between September 1 and December 1, the initial rates issued before February 1, and that adjustments and appeals involving the initial rates completed by March 1. Whatever financial problems have been experienced by some hospitals in this transitional year of 1975 will, it is hoped, not be encountered in the 1976 year.

Donald Kane, of Arthur Anderson & Co., prepared a study at the request of the New Jersey Hospital Association. He made the point (as did others) that hospital trustees act in the public interest and their judgment as to cost should not be impaired. The fallacy here is that the Act delegates to the Commissioners of Health and

Insurance the responsibility for setting rates, and their judgment, reasonably exercised, must prevail.

Mr. Kane expressed the view that the Commissioners, in setting the rate for a particular hospital, act on the basis of assumed facts, average facts and facts developed by others, and this places everyone, including the hospitals, the public and health service corporations in a "tailspin." In his view, the Commissioners must "stick to the economic facts of the particular institution." His criticism is inaccurate. Facts are not assumed, facts are not averaged, as the record fully establishes.

Some of Mr. Kane's testimony was addressed to the New Jersey statute and the current Blue Cross contract with hospitals, rather than to the Guidelines. The statute was not the subject of the hearing. The Blue Cross contract specifies the costs and services it will cover, and has been in effect since 1971. The Commissioners elected to abide by it in reviewing rates, so that only those cost items specified in the contract as reimbursable by Blue Cross were included in setting the 1975 rates. (A similar constraint exists with respect to Medicare aid: federal legislation (*P.L.* 92-603) limits Medicare reimbursements to the amounts that would be determined using Medicare costing principles.) The fact remains that Blue Cross agreed to pay for those who are its subscribers, and no one else. Bad debts and indigent patient costs are excluded under the Blue Cross contract.

There is a further constraint. As stated, the Commissioners were asked to use existing HRET forms and instructions for 1975 rate review. Those forms lack uniform definitions, so that apparently high costs could result from differences in reporting among hospitals. They are also inadequate as regards legally approved or mandated changes, such as the cost impact of Certificate of

Need approved programs. Further, there is an inability to separate direct costs of ancillary and general service functions between inpatients and outpatients. In additions, case mix data are not readily determinable, and this mix of patients varies considerably among hospitals. It was therefore apparent from the outset that reasonable and equivalent rates could not be established entirely from data provided in the forms. Accordingly, initial thinking in developing the Guidelines was to establish criteria which Department analysts would apply and that would discuss at budget review meetings with hospital representatives. These conferences with staff, as well as the appeals process, would soon develop factors that ought to be and indeed are being considered in revising initial rates.

It merits repeating that at a meeting on February 17, 1975 hospital representatives requested that initial rates be issued as quickly as possible in order to improve cash flows. It was suggested that budgetary costs which could be accepted without question be identified and incorporated in the initial rates pending resolution of questioned items. The Commissioners accommodated this request. The record establishes that staff conferences and appeals have resulted in numerous adjustments to the initial rates —a process which undoubtedly will produce like results in the remaining budgets now in the course of re-examination.

In his memorandum expanding upon his summary testimony at the hearing, Mr. Kane projects what he terms "fallacies" in the Guidelines. First, he states that the Guidelines would result in usurping the responsibilities of hospital boards of trustees. I have already commented upon this contention: the Act controls.

Next, he claims that the Guidelines would force operating losses upon health care institutions in failing to recognize the "total costs" provision in *N.J.S.A.* 26:2H-18(d) —costs of necessary patient services would not be recovered in the established rates. By way of example he cites costs in excess of the median for various units of patients' services, and costs incurred during the period the rates are in effect and which were not incurred in the historical base period. What is overlooked is that the statute does not require that the rates fixed shall reimburse hospitals so that they recoup their total outlay; the statute requires no more than that the Commissioners *consider* total costs in determining just what is to be reimbursed. As the Appellate Division said in *Borland vs. McDonough*, Docket A-561-73, decided on the date of this report, "To hold otherwise would divest the Commissioners completely of discretion and actually render unnecessary the approval proceedings required by the Legislature under the statute, thus reducing the Commissioners' duties to nothing more than a rubber stamp." Mr. Kane's claim also ignores the revision of rates made possible after informal conferences with staff analysts and resort to the appeals process. In further support of his contention he cites the fact that bad debts and the cost of charity care are not recognized. They are not because, as just pointed out, they are not included in the Blue Cross contract.

Mr. Kane argues that the Guidelines would jeopardize future ability to serve patients by reason of their failure to recognize the need of hospitals to have a net income. Such net income, he says, would provide adequate working capital needs and adequate coverage of debt interest; it would avoid forced losses, off-set lags in obtaining a revised rate, protect the financial viability of institutions against inflation of costs and provide them with financial

stability. The short answer to all this is that net income is not within the purview of the rate-setting provisions of the Act.

Another of the "fallacies" is addressed to the use of the median. At this point it should be emphasized that the median is not an average of the costs of hospitals in the same group; it is a midpoint cost, as heretofore explained. The criticism of the median by Mr. Kane (and others who spoke) totally ignores the availability of the appeals process which, as stated, has already resulted in an appreciable number of revised initial rates.

Mr. Kane states that the Guidelines set out aribtrary rules and techniques which would defeat the objectives of the Act and be counter-productive in relation to the public interest. Here he points out that in determining hospital departmental costs there cannot be a realistic comparison among institutions. That argument has been mentioned heretofore. Admittedly, hospitals vary in many respects, but data definition (costs centers, peer groupings and units of service) provide a working basis for comparison. In any event, this criticism, like many others, ignores the appeals process. Under this same heading Mr. Kane states that the 12%, 17% and 20% inflation factors for supplies, employees and physicians, respectively, have no basis in fact. As a matter of record, these percentages were adopted after a careful consideration of many elements, including cost of living indices, national and state statistics, and other factors relating to inflation. The percentages are adjustable where a hospital presents persuasive facts to the analyst or on appeal.

An additional argument under the "fallacies" section of the Kane memorandum is that the Guidelines would compel hospitals to reduce the type, scope or quality of patient service, or result in increased rates for self-pay

and commercially insured patients. The fact remains that the Act deals exclusively with what Blue Cross should pay the hospital under its contract, for medical care given to its subscribers. It does not necessarily follow, that a hospital would reduce the level of patient care, and if it is forced to charge increased rates to non-Blue Cross patients, this would not make the Guidelines unreasonable. *Borland vs. Bayonne Hospital*, 122 *N.J. Super.* 387 (Ch. Div. 1973), held that the fact that such patients must pay a higher rate for services identical with those rendered Blue Cross subscribers does not deprive the former of due process or the equal protection of the laws. *Borland* was this day (July 3, 1975) affirmed on the opinion below.

Another "fallacies" argument, expanding upon one noted above, is that the statistical comparison of costs among health care institutions is unreasonable and contrary to the purposes of the Act because it assumes that institutions are so similar as to be identical; and such comparison does not recognize cost differences resulting from variations between hospital programs and services, and does nothing to relate costs to services offered. The Guidelines do not assume that hospitals are so similar as to be identical; they do recognize cost differences between and among hospitals, and the statistical comparisons represent as reasonable an approach to relating costs to services offered as is presently possible. The Guidelines are instinct with a determined effort to make cost comparisons meaningful and reasonable. This report has already referred to the relative difficulty of such comparisons, stemming in the main from the reporting system that had to be resorted to in connection with the 1975 rate-setting process.

A final "fallacy" projected by Mr. Kane is that the provision in the Guidelines for the issuance of the final rate

and appeals therefrom is grossly inadequate in that it is self-serving for the regulators. I find no proven inadequacies. The self-serving charge is directed to section 10 of the appeals rules which states that the final rate shall be determined retrospectively following adjustment of costs included in the original rate, after comparison with the certified actual costs for the budget year. Specifically, Mr. Kane points to the provision that adjustments shall be made for (among other things) such items "as may, in the judgment of the Department, be appropriate." This last, it is said, represents a "one-way street for the regulatory agency's own needs and purposes only." The argument so made assumes a degree of arbitrariness that any responsible administrative agency would avoid, at peril of reversal by the courts on appeal. Final rates have not, of course, yet been determined for 1975, and to assume that the Department of Health will not consider such other items presented by a hospital as could persuasively influence it to adjust the rate is to engage in surmise.

Mr. Kane's memorandum also includes a section on "technical errors" in the Guidelines. I shall briefly deal with some of them:

(1) It is asserted that the Guidelines assume that costs related to increased intensity will be off-set by productivity increases, and this is invalid. The Department acknowledges the error and will correct it.

(2) It is erroneously assumed that personnel cut-backs result in saving the total salary and the fringe benefit costs of positions eliminated. The Department recognizes that employment benefits are legally mandated. Adjustments would be included in the final rate calculation.

(3) The assumption that disallowed personnel hours can be eliminated by June 30, 1975 is unreasonable. The

Department states that where costs questioned in the initial rate calculation result in personnel reductions having to be made after administrative appeals, adjustments are made based on the individual hospital's situation.

(4) The assumptions as to variability of costs are unrealistic, arbitrary and unreasonable. This fails to recognize that the variability factors serve merely as guides; they cannot be defined nor are they applied precisely. The testimony of Mr. Lewin and F. Bernard Forand, Special Assistant to the Rhode Island State Budget Director, was that the variability factors are, as the Guidelines state, within the discreet ranges normally incurred in budgetary control systems. There has been no contradition of Miss Maloney's statement that no one, in the discussions that led to the Guidelines, "felt he could justify the use of other variability factors as being any more reasonable or valid."

(5) The units of service established to compute unit costs in each cost center are frequently not related to the proper unit of patient services. The Department agrees that this is so with respect to indirect costs that may be allocated to outpatients, and this can readily be corrected if properly presented to the Department analyst or on appeal by the affected hospital.

(6) The rate review schedules cause outpatient costs to be eliminated twice in arriving at the inpatient *per diem* rate. The Department asserts that Mr. Kane's statement regarding double elimination of emergency room, clinic and private ambulatory departments is not correct. Should the matter be otherwise, it should immediately be looked into. It goes without saying that any double elimination in arriving at an allowable *per diem* rate should be corrected.

(7) Base year cost are not properly adjusted to reflect a future year's cost for new programs or other changes in service. As regards 1975, I have been assured that this—as well as other technical matters referred to by Mr. Kane—is being dealt with in the course of the administrative appeals process. (See, for example, the testimony of James Hull, Health Department rate analyst.)

(8) The units of service established by the Guidelines to measure volume of activity and to project the effect of volume changes on variable costs are frequently not proper because not directly related to the true underlying levels of service which might affect costs. As an example, Mr. Kane cites the unit of measure for operating and recovery rooms is total acute admissions; a more appropriate unit, he feels, would be some direct measure of usage, such as quarter-hours or minutes of use. The Department points out that unless a hospital's patient mix changes dramatically in the course of a year, total acute admissions is an appropriate indicator of volume changes in the operating room. For the hospital whose patient mix does change, with a resulting impact on the operating and recovery rooms, such changes, where significant, can be dealt with when final rates are approved. The same would be true of Mr. Kane's observations regarding anesthesiology and inhalation therapy. If a case can be made out for volume changes in the hospital pharmacy so that costs are measured by patient days, this, too, can be corrected. The same observation may be made with regard to medical records work, now measured by the number of admissions.

(9) The rate review schedule designed to calculate the allowable salary rate increase fails to recognize changes in employee mix. Further, since new employees would normally be hired at the starting rather than the average

salary rate, the disallowed hours should be costed at the hospital department's budgeted average starting rate. The Department represents that where an employee mix changes to the detriment of a hospital, a correction is identified during the appeal process.

In summary, whatever technical differences flow from the Guidelines can be adjusted upon a proper case being made out by the hospital. In any event, the observations made at the hearing will serve as a basis for further refinement of the Guidelines by the Commissioners in connection with the 1976 rate-setting procedures. Such technicalities do not significantly affect the over-all validity of the Guidelines set down for 1975.

Some of the presentations at the hearing and in statements filed with me refer to items like debt service and depreciation not being adequately reflected in the setting of rates. The record is to the contrary: debt service and depreciation are factors given due weight in the fixing of rates. If, by chance, either of these factors has not been given proper consideration, the matter can be corrected after consultation with the analyst or on appeal, so that the revised initial rate, or at least the final rate, will include these items.

Some of those who appeared claimed that the Commissioners were disallowing expenses growing out of the grant of Certificates of Need, and that in setting rates the Commissioners were reviewing or re-evaluating programs they had previously approved. This, it was asserted, invades the prerogative of hospital trustees in fixing the level and quality of medical services after such services had been authorized by the Certificates of Need. Certificate of Need programs must, of course, find their reflection in the initial rate, revised rate or, at the latest, in the

final rate. The Department is aware that this is so and makes due allowance for such programs.

The New Jersey Hospital Association has filed a position paper addressed to the Guidelines. The position paper first states what is obviously true, namely, that any regulations adopted by the Commissioners to implement their statutory duty under *N.J.S.* 26:2H-18(d) must carry out the stated policy of the Health Care Facilities Planning Act, namely, approval of reasonable rates compatible with highest quality health care services.

NJHA, in Point 1 of its paper, attacks the median concept, stating that it subjects costs over the median to automatic challenge and disallowance, and disregards the decision of the hospital board that a certain level of staffing is necessary to provide the quality of care mandated by the hospital's charter and trustees. The result, it is said, effectively lowers the quality of care being offered by the top half of the hospitals by disallowing costs associated with such care. I find that such a standard of disallowance is also used by the Federal Government: a hospital is refused payment to the extent that a proposed cost falls above a certain percentile for all hospitals in its classification. (See notice by the U.S. Department of Health, Education and Welfare, issued on May 30, 1975 and appearing in the *Federal Register*.)

The Guidelines do not subject hospital costs over the median to "automatic challenge and disallowance." The Guidelines are clear that once the initial rate is established, a health care facility may file an appeal; section 8 of the proposed rules concerning 1975 hospital rate review directs that after a public hearing, "The agency chief shall render decisions in matters of apparent inequities where facts can be determined readily, and on issues peculiar to one institution . . ." The use of the

median as a screening device was, as earlier mentioned, supported by experts in the medical care rate-setting field.

The position paper also asserts that the Commissioners "have applied a formula approach [that] does not consider the unique characteristics of each health care facility," resulting in an unreasonable reduction in reimbursement rates which has no relationship to the scope, level or quality of care being rendered by the particular health care facility. Here, again, there is little appreciation of the salutary corrective process available through informal discussions with the Department analysts and through the appeals process.

The observation made in the first part of the position paper that the Guidelines do not allow a hospital to generate net income in order to provide for its capital needs, cover short and long-term debt and, in general, protect its financial viability and stability, has been the subject of my prior observation on that matter.

Point 2 of the NJHA position paper discusses services provided by a health care institution pursuant to a Certificate of Need and contends that any attempt, in the rate review process, to implicitly or explicitly reduce the level of service being offered, is contrary to the Act. To state NJHA's position fully, it maintains that once a Certificate of Need has been granted, the health care facility may implement the approved program. The Guidelines, it is said, would effectively provide for a re-review of such programs by disallowing reimbursement for annual costs approved by the Certificate of Need in 1974 or approved prior to that time but instituted in 1974. I have already addressed myself to this argument.

Point 3 of the position paper argues that the Guidelines must comply with substantive due process; there must be no unlawful interference with the operation of a health

care facility by establishing a reimbursement rate which fails to compensate it in a reasonable manner for costs incurred in health care delivery. It is contended that the Commissioners must, in adopting a regulatory scheme, not substitute their judgment for that of the management (the board of trustees) of the institution. The argument so made centers upon the median concept and the allegedly arbitrary wage rate increase percentages. I do not find this claim valid. The Guidelines provide in detail for as reasonable a reimbursement as can be derived from the cost figures submitted by the respective hospitals, considered in light of the data definitions, the method for determining reasonableness and the quantification provisions of the Guidelines already referred to.

This section of the position paper also argues that Blue Cross patients should be made to pay their fair share of total costs, and this is not accomplished because of the elimination from the Blue Cross rate of the cost of bad debts and charity cases. I have earlier dealt with this precise argument, and the *Borland* case, cited by NJHA, has disposed of the constitutional issue that non-Blue Cross patients are unfairly charged a different rate from those insured by Blue Cross. In any event, the due process and equal protection of the laws argument is for the courts, and not for this hearer to determine.

While Point 3 deals with substantive due process, Point 4 deals with the question of procedural due process. It is argued that the adjudication of disputed facts is different from and may not mask as rule-making. Examples given of the adjudication of disputed facts are the classification of hospitals, the use of equivalent units, the classification of costs (variable, semi-variable and fixed) and the 12%, 17% and 20% inflation figures. It is urged by NJHA that

> In passing upon the reasonableness of the reimbursement rate, the uniqueness, geography, individuality, service area, labor market, patient mix, size, educational programs, general industry standards and inflation are to be considered. Further, the reimbursement rate should be one which assures that the health care facility recovers the total cost reasonably and efficiently incurred in providing health care services. Therefore the reimbursement rate should include the following elements:
>
> 1. Current operating needs such as the direct patient care, operating expenses, education, research, charitable allowances and depreciation;
>
> 2. Plant capital needs such as preservation and replacement of existing facilities, acquisition of new technology, and statutorily approved expansion;
>
> 3. Working capital and operating cash needs;
>
> 4. The provision of a reasonable profit or net income.
>
> Items 2, 3 and 4, as heretofore noted, are not valid considerations in the setting of rates under the Act; the remainder of the recommendation involves elements already considered by the Commissioners.

The suggestion that provision should be made for a hearing at which a hospital is afforded the opportunity to appear and present evidence and argument on contested issue has merit. My understanding is that the public hearing afforded a hospital on administrative appeal and on appeal to the Commissioners' Appeals Board gives hospitals this very opportunity. My suggestion is that the proceedings on formal appeal be recorded, if that procedure is not now followed. There is no need evident for

creating such a record at the informal conference with the Department analyst; indeed, NJSA does not consider a formal record necessary.

As for the time schedule for presenting proposed budgets, processing them, supplying the health care facility with written comments concerning its proposed budget and requested reimbursement rate, the informal meeting with the analyst, the issuance of the initial rate and the holding of any subsequent appeal—such matters are addressed to a schedule which the Commissioners intend to follow after the present transitional period.

The section of NJHA's position paper entitled "Disallowances resulting from the proposed regulation should not apply retroactively" is not persuasive. The initial rate fixed by the Commissioners, and adjustments to that rate, are applied back to the beginning of the fiscal year, January 1, and Blue Cross is notified to pay the new rate as if it had been applicable since that date. Hospitals should realize that their cost figure is subject to review, and if that review results in disallowance of any item or items so as to reduce the proposed rate, it should in strict logic be retroactive to January 1.

Whatever comments were made at the hearing with respect to improvements in the Health Care Facilities Planning Act are properly addressed to the Legislature, as are those dealing with the statute relating to Blue Cross contracts, *N.J.S.A.* 17:48-7 and 8. Arguments as to constitutionality, on due process and equal protection grounds, must be resolved by the courts.

Considering that 1975 is a year of transition, that the Commissioners were obliged to use the HRET budget forms in order to accommodate the hospitals' desire for an early setting of initial rates in order to help their cash

flow, and that there exists a practical procedure for adjusting rates by informal conferences and, if necessary, by appeals, I find that the Guidelines, considered in their entirety, fairly meet the statutory public policy of reasonableness in setting rates that will enable hospitals to provide health care services of highest quality and of a demonstrated need, efficiently provided and properly utilized at reasonable cost. A thorough review of the presentations made at and after the hearing, including the exhibits, provides adequate support for this conclusion.

The hearing has served the good purpose of providing an airing of criticisms addressed to the proposed Guidelines. I am confident that some of them will provide the Commissioners with helpful suggestions for refinements and technical improvements.

/s/ Sidney Goldmann
SIDNEY GOLDMANN, Hearer

DATED: July 3, 1975.

AFFIDAVIT OF J. AUSTIN WHITE, AS FILED IN THE CASE OF BETH ISRAEL HOSPITAL, et al v. JOANNE E. FINLEY, et al, DOCKET NO. A-2039-74, IN WHICH SOME OF THE DEFENDANTS HEREIN WERE PLAINTIFFS

STATE OF NEW JERSEY)
) SS.:
COUNTY OF MERCER)

I, J. AUSTIN WHITE, of full age and being duly sworn according to law, upon my oath depose and say:

1. I am the Administrator of Hamilton Hospital which is located in the Township of Hamilton, County of Mercer and State of New Jersey.

2. Hamilton Hospital was founded in 1941 in Trenton, New Jersey. On November 15, 1971, the hospital moved to a new 113 bed facility in Hamilton Township. The State Department of Health issued a new license to the hospital and the Hospital Service Plan of N.J. required the hospital to enter into a new provider contract. The debt at time of opening was $4,000,000 F.H.A. mortgage and a $600,000 demand note secured by our pledges receivable.

Under the new Service Plan contract, the hospital was forced to accept a negotiated rate. This negotiated reimbursement rate did not provide for adequate depreciation and debt service. Funding of depreciation was required under our F.H.A. mortgage agreement.

In 1972 with an 80.4% occupancy, our certified cost was $98.44. The negotiated rate, based on the weighted average of four area hospitals, was $86.45 or $12.00 per day under our actual certified cost. In 1973, the hospital's

certified cost was $98.72 and the negotiated rate was $96.60 or $2.12 under the certified cost. This resulted in a Blue Cross deficit for 1972 and 1973 of approximately $246,750.

Seventy-five percent of the hospital's patients were covered by the Hospital Service Plan of N.J., Medicare and Medicaid contracts that normally provide cost recovery or charges, whichever is less. Another 20% paid charges and 5% were charity or non-collectibles.

The hospital has no endowment income or funds. The Blue Cross deficit had to be subsidized by the small balance of our patients who pay charges.

The 1974 operating budget was prepared under Phase III Rules and in anticipation of Phase IV of the Economic Stabilization Act. The subsequent removal of controls, the accelerated inflation rate, and the formulistic approach to hospital reimbursement has caused a major cash flow problem for Hamilton Hospital.

In March New Jersey hospitals were granted a 5% temporary increase on the 1973 per diem rate effective January 1, 1974. In the case of Hamilton Hospital, the increase was calculated on the 1973 negotiated rate of $96.60 rather than the anticipated certified cost of $98.77. This resulted in a temporary rate of $101.50 although the budgeted cost under the Federal economic controls was $110.18. Thus, a negative cash flow situation existed.

On August 28, 1974, Hamilton Hospital was granted a new tentative per diem rate of $107.10. This adjustment did not adequately take into account the inflation factor and thus, the negative cash flow position persisted.

The next and final adjustment was granted on September 16, 1974, as an energy adjustment of 3.3 cents per kilowatt hour and an economic projection factor increase

from 7½% to 9%. The tentative per diem thus became $110.40 and has so continued.

Our audited cost for 1974 is $123.78. It should be noted that in spite of the inflationary pressures created by sizable mid-year salary increases granted by neighboring hospitals, Hamilton stayed within its original payroll budget. The increases were in areas of food, power, medical, surgical and other supplies over which we had little control.

The lack of timeliness in the setting of reasonable reimbursement rates has created serious cash flow problems. This problem has been further aggravated by the hospitals' effort to reduce the patient length of stay.

Hamilton Hospital had an average length of stay of 8.9 days in 1972, 8.3 days in 1973 and 7.4 days in 1974 which is one-half a day under the budgeted length of stay for 1974. Although the hospital increased its admissions by 320 patients or 7½% over 1973, there was a net loss in patient days of 4.3%. The drop of 1,866 patient days under budget represented reduction of approximately 875 Blue Cross days or $96,000 at the interim approved rate of $110.40.

Although the patient days decreased, it did not have a comparable decrease in the ancillary departments. In fact, with the increase in admissions, most of the ancillary departments had an increase in productivity over budget for inpatients as follows:

	Budget	Actual
Radiology Procedures	9,150	10,309
Operations (2 rooms operating)	2,400	2,541
Laboratory Tests	65,800	65,172
EKG Examinations	3,520	4,184
Radioisotope Procedures	450	603

It is readily apparent that the intensity of care increased with the increase in admissions and the shortening of stay. The faster turnover of patients increased the need for cash.

The relatively small size of the hospital and the high fixed cost requires that the hospital function within very limited perimeters. A decrease of 11 patients represents 10% reduction in our inpatient income assuming 100% occupancy base.

Our daily cash needs are as follows:

Salaries & Wages	$ 7,400
Physician Fees	600
Supplies & Expenses	4,400
	$12,400
Debt Service	1,100
Funded Depreciation	500
Total Daily Cash Needs	$14,000
Source of Funds:	
Outpatient Provides	$ 2,500
Other non-patients	200
Inpatients have to provide (Average Daily Census 93.2 x $121.25)–	11,300
Total	$14,000

The daily cash loss on Blue Cross patients at an average daily census of 45 patients is $488.00 ($121.25 average daily per diem reimbursement need at a 93.2 daily census less $110.40 current reimbursement–$10.85 per patient x 45 patient days = $488.00 daily loss).

The high fixed costs and the sensitivity to census changes can be readily seen. The hospital survived a major census drop in November and December of 1974 by taking drastic short-term measures including reduction of all salaries and wages to approximately a 37½ hour level (a number of employees took time off without pay and vacan-

cies were left unfilled), by reducing inventories to an absolute minimal level, and by withholding payments to vendors in excess of 90 days. The latter resulted in the utility vendors threatening to cut service. Dietary vendors placed the hospital on C.O.D. and a major medical supplier added 1½% on all balances over 60 days.

Long-term measures to control cost include in-house management engineering, staffing levels for all departments with weekly staffing reports, and vacancies are being filled only where there would be a major impact on patient services.

Hamilton Hospital is due approximately $200,000 in retroactive adjustments for funds expended on behalf of Blue Cross patients treated at Hamilton Hospital and is in need of an interim adjustment of approximately $100,000 to provide the liquidity for prudent financial management of the hospital.

The hospital has absolutely no cash reserve and thus, depends solely on patient income to meet its operating expenses. Any downward change in patient admissions would create an immediate financial crises.

Further, due to the hospital's heavy indebtedness, its borrowing ability is extremely limited. We, therefore, must look to the timely recovery of funds due us under our contractural arrangement with the Hospital Service Plan of New Jersey.

Sworn to and Subscribed before me this 4th day of March, 1975.

/s/ J. Austin White
J. AUSTIN WHITE

/s/ Linda L. Applin
LINDA L. APPLIN
Notary Public of New Jersey
My Commission Expires: 2/8/79

LETTER OF DAVID FEINSILVER, ESQ. TO JUDGE MATTHEWS, FRITZ AND BOTTER RE: DECISION, BORLAND et al v. McDONOUGH, et al

July 9, 1975

Honorable Robert A. Matthews
United Professional Building
Union Avenue
Brielle, New Jersey 08730

Honorable John W. Fritz
West High Street
Somerville, New Jersey 08876

Honorable Theodore I. Botter
Court House
Hackensack, New Jersey 07601

Re: John Borland, Jr., et al. v. Richard McDonough, et al. Docket No. A-561-73

Dear Honorable Sirs:

Our office is in receipt of your decision dated July 3, 1975 in the above-captioned matter. After carefully reading said decision, we feel compelled to respectfully request that you indulge the plaintiffs with a clarification of the meaning and legal effect of the very last paragraph appearing on page four of said decision wherein you have acknowledged that hearings must be held prior to the setting of reimbursement rates. See also *Monmouth Medical Center, et al. v. State of New Jersey, et al.*, docket numbers A-2147-74 to A-2151-74, incl.

In our briefs and at oral argument, we strongly took the position that the Commissioners, in promulgating their rules and regulations and in setting the Blue Cross rates,

pursuant to their respective responsibilities under the provisions of *N.J.S.A.* 26:2H-18(c) and (d) and *N.J.S.A.* 52:14B-4(a) and otherwise failed to provide the plaintiffs, the hospitals, and all other affected parties the due process guarantees of notice and opportunity to be heard, thereby rendering all such rules, regulations, and especially rates, to be null, void and of no effect. Our arguments with respect to this issue were substantially ignored by the repondents.

After due consideration of your decision, it appears to the undersigned that the logical inference to be drawn from said paragraph is that since the rules, regulations, and rates were not properly established, that they must fall.

Whereas your opinion does not appear to provide a statement illuminating the legal effect of your conclusion in said paragraph, we would be most grateful if you could give us further guidance.

In the event that you would deem further oral argument on this issue to be more appropriate and/or meaningful, then, in that event, we most respectfully request that this matter be set down for a rehearing on said issue.

Respectfully yours,

KRIEGER & CHODASH

By: /s/ David Feinsilver
DAVID FEINSILVER

DF:sgd
cc: Omer F. Brown, II
Deputy Attorney General

Mrs. Elizabeth McLaughlin
Clerk of the Appellate Div.

LETTER OF HON. ROBERT A. MATTHEWS, P.J.A.D. TO DAVID FEINSILVER IN REPLY

July 11, 1975

David Feinsilver, Esq.
Messrs. Krieger & Chodash
921 Bergen Avenue
Jersey City, New Jersey 07306

Re: John Borland, Jr., et al. v. Richard McDonough, et al. A-561-73

Dear Mr. Feinsilver:

This is in response to your letter of July 9, 1975, concerning the above mentioned matter. It is not appropriate for us to take any further action on the basis of your letter.

Very truly yours,

/s/ Robert A. Matthews
ROBERT A. MATTHEWS
P.J.A.D.

RAM:bs
cc: Hon. John W. Fritz
Hon. Theodore I. Botter
Omer F. Brown, II, Deputy
Attorney General
Mrs. Elizabeth McLaughlin
Clerk, Appellate Division

NOTICE OF APPEAL TO SUPREME COURT
IN BORLAND, et al v.
BAYONNE HOSPITAL, et al

Notice is hereby given that plaintiff-appellants, John Borland, Jr., et al, appeal to the Supreme Court of New Jersey from the Final Judgment of the Appellate Division of the Superior Court (the judges sitting therein being Matthews, Fritz, and Botter), entered in favor of Defendants-Respondents on July 3, 1975.

KRIEGER & CHODASH
Attorneys for Appellants

By /s/ David Feinsilver
DAVID FEINSILVER

Dated: August 15, 1975

NOTICE OF APPEAL TO SUPREME COURT
IN BORLAND, et al v. RICHARD McDONOUGH, et al

Notice is hereby given that appellants, John Borland, Jr., et al, appeal to the Supreme Court of New Jersey from the Final Judgment of the Appellate Division of the Superior Court (the judges sitting therein being Matthews, Fritz, and Botter), entered in favor of Respondents on July 3, 1975.

KRIEGER & CHODASH
Attorneys for Appellants

By: /s/ David Feinsilver
DAVID FEINSILVER

Dated: August 15, 1975

PETITION FOR EXTENSION OF TIME TO FILE APPELLANTS' BRIEF IN BORLAND, et al v. BAYONNE HOSPITAL, et al

(Filed October 7, 1975)

TO: THE HONORABLE RICHARD J. HUGHES
Chief Justice of the Supreme Court of New Jersey:

The petition of the plaintiffs-appellants, John Borland, Jr., et al, respectfully shows that:

1. The plaintiffs-appellants filed a Notice of Appeal in this case on August 19, 1975.

2. On July 3, 1975, the Appellate Division of the Superior Court (The Honorable Judges Matthews, Fritz and Botter) entered Final Judgment in favor of Respondents.

3. The copies of the Briefs and Appendices of the plaintiffs-appellants should be served on or before October 3, 1975.

4. The plaintiffs-appellants desire permission for the extension of the time for the serving and filing of the copies of their Briefs and Appendices until the 3rd day of November, 1975.

5. No previous extension of time has been made in the appeal of this case.

6. The plaintiffs-appellants request the aforesaid extension of time as a result of extensive calendar and other commitments that would foreclose giving the complex and intricate issues of this matter the proper treatment. Plaintiffs-appellants submit that the prayed for extension would serve the best interests of justice as the matters raised in this action are of grave import to the populace of New Jersey and deserve to be presented to, and determined by, the court in such a way as to result in an adjudication on the merits.

WHEREFORE, the plaintiffs-appellants pray, for the reasons set forth herein, that this Court may grant an Order extending the time for the serving and filing of their Briefs and Appendices from the 3rd day of October, 1975 until the 3rd day of November, 1975.

Respectfully submitted,

KRIEGER & CHODASH
Attorneys for
Plaintiffs-Appellants

By: /s/ David Feinsilver
DAVID FEINSILVER

DATED: Sept. 22, 1975.

CERTIFICATION OF VERIFICATION

I, DAVID FEINSILVER, attorney for the above named plaintiffs-appellants do hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to punishment.

/s/ David Feinsilver
DAVID FEINSILVER
Attorney for
Plaintiffs-Appellants

DATED: Sept. 22, 1975.

CONSENT ORDER TO EXTEND TIME
(Filed October 7, 1975)

This matter having been brought to the attention of the Court by David Feinsilver, Esq., attorney for plaintiffs-appellants, on a verified petition praying for the extension of the time for the service of the copies of the Briefs and Appendices by the plaintiffs-appellants from the 3rd day of October, 1975 until the 3rd day of November, 1975, and the attorneys for defendants-respondents having duly consented to the entry of the Order,

It is therefore, on this 7th day of October , 1975,

ORDERED that the time within which the plaintiffs-appellants, John Borland, Jr., et al, shall serve and file their Briefs and Appendices on this appeal shall be and the same is hereby extended and enlarged from the 3rd day of October, 1975 until the 3rd day of November, 1975.

/s/ Richard J. Hughes
RICHARD J. HUGHES,
Chief Justice

By: /s/ Florence R. Peskoe

We hereby consent to the entry and form of the foregoing Order.

PITNEY, HARDIN & KIPP
Attorneys for
Respondent-Hospital Service
Plan of New Jersey

By: /s/ Clyde A. Szuch
CLYDE A. SZUCH

DATED: September 23, 1975.

LOWENSTEIN, SANDLER,
BROCHIN, KOHL & FISHER
Attorneys for
Respondent-Hospitals

By: /s/ Bruce D. Shoulson
BRUCE D. SHOULSON

DATED: , 1975.

PETITION FOR EXTENSION OF TIME TO FILE APPELLANTS' BRIEF IN BORLAND, et al v. RICHARD McDONOUGH, et al

(Filed October 7, 1975)

TO: THE HONORABLE RICHARD J. HUGHES
Chief Justice of the Supreme Court of New Jersey:

The petition of the plaintiffs-appellants, John Borland, Jr., et al, respectfully shows that:

1. The plaintiffs-appellants filed a Notice of Appeal in this case on August 19, 1975.

2. On July 3, 1975, the Appellate Division of the Superior Court (The Honorable Judges Matthews, Fritz and Botter) entered Final Judgment in favor of Respondents.

3. The copies of the Briefs and Appendices of the plaintiffs-appellants should be served on or before October 3, 1975.

4. The plaintiffs-appellants desire permission for the extension of the time for the serving and filing of the copies of their Briefs and Appendices until the 3rd day of November, 1975.

5. No previous extension of time has been made in the appeal of this case.

6. The plaintiffs-appellants request the aforesaid extension of time as a result of extensive calendar and other commitments that would foreclose giving the complex and intricate issues of this matter the proper treatment. Plaintiffs-appellants submit that the prayed for extension would serve the best interests of justice as the matters raised in this action are of grave import to the populace of New Jersey and deserve to be presented to, and determined by,

the court in such a way as to result in an adjudication on the merits.

WHEREFORE, the plaintiffs-appellants pray, for the reasons set forth herein, that this Court may grant an Order extending the time for the serving and filing of their Briefs and Appendices from the 3rd day of October, 1975 until the 3rd day of November, 1975.

Respectfully submitted,

KRIEGER & CHODASH
Attorneys for
Plaintiffs-Appellants

By: /s/ David Feinsilver
DAVID FEINSILVER

DATED: Sept 22, 1975.

CERTIFICATION OF VERIFICATION

I, DAVID FEINSILVER, attorney for the above named plaintiffs-appellants do hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to punishment.

/s/ David Feinsilver
DAVID FEINSILVER
Attorney for Plaintiffs-Appellants

DATED: Sept 22, 1975.

CONSENT ORDER TO EXTEND TIME
(Filed October 7, 1975)

This matter having been brought to the attention of the Court by David Feinsilver, Esq., attorney for plaintiffs-appellants, on a verified petition praying for the extension of the time for the service of the copies of the Briefs and Appendices by the plaintiffs-appellants from the 3rd day of October, 1975 until the 3rd day of November, 1975, and the attorneys for defendants-respondents having duly consented to the entry of the Order,

It is therefore, on this 7th day of October, 1975,

ORDERED that the time within which the plaintiffs-appellants, John Borland, Jr., et al, shall serve and file their Briefs and Appendices on this appeal shall be and the same is hereby extended and enlarged from the 3rd day of October, 1975 until the 3rd day of November, 1975.

/s/ Richard J. Hughes
RICHARD J. HUGHES,
Chief Justice

By: /s/ Florence R. Peskoe

I hereby consent to the entry and form of the foregoing Order.

WILLIAM F. HYLAND
Attorney General of New Jersey
Attorney for Respondent
Commissioners

By: /s/ Herbert K. Glickman
HERBERT K. GLICKMAN
Deputy Attorney General

DATED: , 1975